

FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4010 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03996

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 23 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. STREET ADDRESS R.F.D. #5 Fairgo	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Robert Abbott		First Charles	Middle Robert
4. DATE OF DEATH April 19 1958	Month April	Day 19	Year 1958
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 24 1933
9. AGE (In years last birthday) 24 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman	11. KIND OF BUSINESS OR INDUSTRY B&O R.R.y.	12. BIRTHPLACE (State or foreign country) Romney, W.Va.
13. FATHER'S NAME Robert Abbott	14. MOTHER'S MAIDEN NAME Kathleen Speelman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. Korean	17. INFORMANT 220-28-7622 Hospital records-	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Concussion & contusion of brain INTERVAL BETWEEN ONSLET AND DEATH 23 days			
816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) with laceration of main stem.			
DUE TO (c) Collision between two trucks. 23 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) going west.			
Passenger in truck going east, collided with a truck			
20c. TIME OF INJURY Hour 9.45 p.m.	Month, Day, Year March 27 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 220, near Rawlings, Allegany, Md.
20f. (City or town) Allegany	(County) Allegany	(State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H. V. Deming M.D.</i>	DATE SIGNED		
EXAMINER'S NAME (Type) H. V. Deming M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 20-1958		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/22/58	22c. NAME OF CEMETERY OR CREMATORIUM Rest Lawn Memorial Gardens	22d. LOCATION (City, town, or county) Cumberland, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Maryland	ADDRESS	24a. REC'D BY REGISTRAR DATE APR 24 '58	24b. REGISTRAR'S SIGNATURE <i>O. J. Smith</i>

BUREAU X-1

APR 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4011 CERTIFICATE OF DEATH

03997

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-trousser permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS RT. #1, HOMEWOOD ADDITION		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) CLEVELAND		First ALBRIGHT	Middle T.	Last ALBRIGHT	4. DATE OF DEATH APRIL 18 1958	Month APRIL	Day 18	Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 9, 1881	9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Bookkeeper		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME SAMUEL H. ALBRIGHT		14. MOTHER'S MAIDEN NAME LAURA J. BUCHANAN						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yea, no, or unknown) No		16. SOCIAL SECURITY NO. 220-03-7508A		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Atherosclerotic Heart Disease (c)						INTERVAL BETWEEN ONSET AND DEATH 1 week		
						1 year		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Greene St.	(County) Cumberland, Md.	(State) Md.	
21. I certify that I attended the deceased from 11-2 1958 to 4-18 1958 , that I last saw the deceased alive on 4-17 1958 , and that death occurred at 12:32 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Greene St. DATE SIGNED 4-18-58								
ACTUAL SIGNATURE <i>Rage 6 Baen</i>	M.D.							
PHYSICIAN'S NAME (Type) DR. BALLIN								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/29/58	22c. NAME OF CEMETERY OR CREMATORIAL Fairview Cem.	22d. LOCATION (City, town, or county) Greenridge Mt. Md.		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lam's Stein Inc. Cumb Md</i>	ADDRESS Cumb Md	24a. RECD BY REGISTRAR APR 21 '58		24b. REGISTRAR'S SIGNATURE <i>D. L. Ballin</i>				

MISSOURI STATE PENITENTIARY—OUTLAW

CERTIFICATE OF DEATH

RECEIVED
APR 21 1968
REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03998

4012

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 34 DAYS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				
f. STREET ADDRESS 502 CUMBERLAND STREET		g. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First MARY	Middle L.	Last ASHBY			
4. DATE OF DEATH	Month APRIL	Day 6	Year 1958			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH AUGUST 8, 1894			
9. AGE (In years lost birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS. Days 1	12. Hours 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	11. BIRTHPLACE (State or foreign country) ELK GARDEN, W. VA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CHARLES ASHBY		14. MOTHER'S MAIDEN NAME MATILDA WALSH				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 214-05-8658	17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREKIA 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) HYPERTENSIVE AND ARTERIOSCLEROTIC DUE TO CARDIOVASCULAR AND RENAL DISEASE (c)			INTERVAL BETWEEN ONSET AND DEATH 24 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) ELK GARDEN	(County) W. VA.	(State) MD.
21. I certify that I attended the deceased from NOV 1957 to 17 PR 6 1958 , that I last saw the deceased alive on 17 PR 5 1958 , and that death occurred at 5:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Elk Garden, W. Va. DATE SIGNED 4/6/58						
ACTUAL SIGNATURE <i>Alvin Weisman</i>	PHYSICIAN'S NAME (Type) DR. S.G. WEISMAN					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 8 1958	22c. NAME OF CEMETERY OR CREMATORIUM Nethen Hill Cemetery	22d. LOCATION (City, town, or county) ELK GARDEN	22e. (State) W. Va.		
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE APR 8 '58	24b. REGISTRAR'S SIGNATURE <i>Alvin Weisman</i>		

CERTIFICATE OF DEATH

BUREAU K-5

APR 8 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03999

4313

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2/20/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Grace	Middle Nellie	Last Ball
4. DATE OF DEATH April 7, 1958	Month April	Day 7	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/28/1884
9. AGE (In years at first birthday) 74	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Jacob Leonard	14. MOTHER'S MAIDEN NAME Martha Carpenter		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT P. O. Box 599 Allegany County Infirmary Records	Address Cumberland, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Neuroleptitis, chronic Senile</i> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>encephalitis</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/20/58 , 19, to 4/7/58 , 19, that I last saw the deceased alive on 4/7/58 , 19, and that death occurred at 10:40A , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Lee B. Mathews Jr.</i>		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 4/8/58	
PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 10, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Crown Hill Cemetery	22d. LOCATION (City, town, or county) Hudson, Ohio (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>James H. Hyndman</i>	ADDRESS Pittsburgh, Pennsylvania	24a. REC'D BY REGISTRAR DATE APR 11 '58	24b. REGISTRAR'S SIGNATURE <i>Albert E. Eddick</i>

BUREAU V. 2

APR 11 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4914

CERTIFICATE OF DEATH

04000

Reg. Dist. No.

PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN lb

3/3/58

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Allegany County Infirmary

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

22 Frostburg

d. STREET ADDRESS

Box 352, RFD #1

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
HesterMiddle
J.Last
Barber4. DATE
OF
DEATHMonth
AprilDay
14, 19 58
Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)
85 yrs.10. IF UNDER 1 YEAR
Months11. IF UNDER 24 HRS.
Days

Hours

Min.

Female

White

WIDOWED DIVORCED

6/16/1872

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Loar Town, Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Shadwick Loar

14. MOTHER'S MAIDEN NAME

Elizabeth Humbertson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT P.O.Box 599

Address Cumberland, Md.

(If yes, give war or dates of service)

None

Allegany County Infirmary Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4221

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

↓

(c)

Hypertension, Severe degenerative
Arteriosclerosis, chronic
General.INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
While Not while
of work of work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 3/3/58, 19, to 4/14/58, 19, that I last saw the deceased
alive on 4/13/58, 19, and that death occurred at 4:30A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

R. Mathews

49 Greene Street

4/14/58

PHYSICIAN'S
NAME (Type)

Dr. Lee B. Mathews

Cumberland, Maryland

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial22b. DATE THEREOF
4-16-5822c. NAME OF CEMETERY OR CREMATORIUM
Loar Cemetery22d. LOCATION (City, town, or county)
Vale Summit,

(State)

Md.

23. FUNERAL DIRECTOR'S SIGNATURE

J. R. Durst,

ADDRESS

Frostburg, Md.

24a. REGISTRATION-REGISTRAR
DATE 4/14/58

DATE

24b. REGISTRAR'S SIGNATURE
Alt. Leach

BUREAU X-1

MAR 17 1959

RECEIVED

FOR STATE
HEALTH DEPT.

4097
Allegany
MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04001

Reg. Dist. No.

Please
execute the certificate
if any delay is necessary.
A should be forwarded to the Chief Medical Examiner's Office along with form PM2. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

rural

1. PLACE OF DEATH a. COUNTY		4097 Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Star Rt, Flintstone		c. LENGTH OF STAY IN lb 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Star Route, Flintstone		d. STREET ADDRESS (Green Ridge)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (Green Ridge)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Dennis	Middle Grady	Last Barnes	4. DATE OF DEATH	Month April	Day 6	Year 1958
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH April 16-1875	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Town Hill, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Carlton Barnes		14. MOTHER'S MAIDEN NAME Nancey Hartsock						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Hatty Swartzweller, Rt. #1 Cumberland, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Myocardial failure				INTERVAL BETWEEN ONSET AND DEATH Sudden		
+ Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last.		DUE TO Arteriosclerosis				?		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>		NAME (Type) H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 6-1958		
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 8, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Fairview Christian Cemetery	22d. LOCATION (City, town, or county) Nr. Artemas, Pennsylvania		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 10 '58		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>		

BUREAU V. S.

73 10 1958

DEPARTMENT OF

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4715

CERTIFICATE OF DEATH

04002

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 1 yr., 5 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		d. STREET ADDRESS 126 Humbird St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Emory	Middle Milford	Last Beall	4. DATE OF DEATH April 1 1958	Month Day Year	Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 13, 1867	9. AGE (In years lost birthday) 90 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME George H. Beall		14. MOTHER'S MAIDEN NAME Rose Anna Rice					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No	16. SOCIAL SECURITY NO NONE	17. INFORMANT William Beall, 1705 Forest Glen Rd. Silver Spring, Maryland	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 522 Pulmonary Hypertosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 450 Cerebral arteriosclerosis (b) DUE TO 422 Chronic Myocardial Degeneration				INTERVAL BETWEEN ONSET AND DEATH 72 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 304 Senile psychosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from Nov. 15, 1956 , to Apr. 1st 1958 , that I last saw the deceased alive on Mar. 31st 1958 , and that death occurred at 5 P.M. , from the causes and on the date stated above		ADDRESS (Street, city or town, state) 49 Greene St.		DATE SIGNED 4-2-58			
ACTUAL SIGNATURE James E. McLean, M.D.		PHYSICIAN'S NAME (Type) James E. McLean, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 4, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	22d. LOCATION (City, town, or county) Cumberland, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		ADDRESS	24a. REC'D BY REGISTRAR APR 7 '58	24b. REGISTRAR'S SIGNATURE Alt. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

RECEIVED
FEBRUARY 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4016

CERTIFICATE OF DEATH

04603

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: All or this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First PETER	Middle E.	Last BERRY
4. DATE OF DEATH	Month APRIL	Day 16	Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 11
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUMBERLAND, MD. CO. COURT HOUSE OF		10b. KIND OF BUSINESS OR INDUSTRY VIRGINIA	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES H. BERRY		14. MOTHER'S MAIDEN NAME SUSAN BOUTCHARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL - CUMBERLAND, MD.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] 450.0		INTERVAL BETWEEN ONSET AND DEATH 10-10-1	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerosis		DUE TO Arteriosclerosis	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/16/58 , 19, to 4/16/58 , 19, that I last saw the deceased alive on 4/15/58 , 19, and that death occurred at 3:50 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE B. Williams, M.D.		ADDRESS (Street, city or town, state) Cumberlnd, Md. DATE SIGNED 4/16/58	
PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 17, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc. Cumberland, Md.		24a. REC'D BY REGISTRAR DATE APR 18 '58	
		24b. REGISTRAR'S SIGNATURE Al. Seach	

SURÉAU V. S

DE GELVÉE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Form 0227, 4/11/55

CERTIFICATE OF DEATH

Reg. Dist. No.

04004

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS 220 Paca Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First EDWARD	Middle Henry	4. DATE OF DEATH April 11, 1958	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov 7, 1906	9. AGE (In years lost birthday) 51 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Filtration employee		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Pittsburg, Penna.			
13. FATHER'S NAME Sylvester Borgman		14. MOTHER'S MAIDEN NAME Annie Greaser		Address Silver Springs, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No,		16. SOCIAL SECURITY NO. 214-07-1637		17. INFORMANT Mr. Eugene S. Borgman		INTERVAL BETWEEN ONSET AND DEATH 5 days	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 334X DUE TO Cryptic stroke		DUE TO arterial hypertension		DUE TO 1 year			
Conditions, if any, which gave rise to immediate cause (a), stoning the underlying cause lost. (b) DUE TO		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 57 Greene St., Cumberland, Md.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-30 , 19 58 , to 4-4- , 19 58 , that I last saw the deceased alive on 4-4- , 19 58 , and that death occurred at 26 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 57 Greene St., Cumberland, Md.							
ACTUAL SIGNATURE L. Brings		DATE SIGNED 4-5-58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/58		22c. NAME OF CEMETERY OR CREMATORIUM St. Ambrose Cemetery		22d. LOCATION (City, town, or county) (State) Cresaptown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE APR 8 '58		24b. REGISTRAR'S SIGNATURE Albert Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPRAU V. S

DEPRAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04005

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

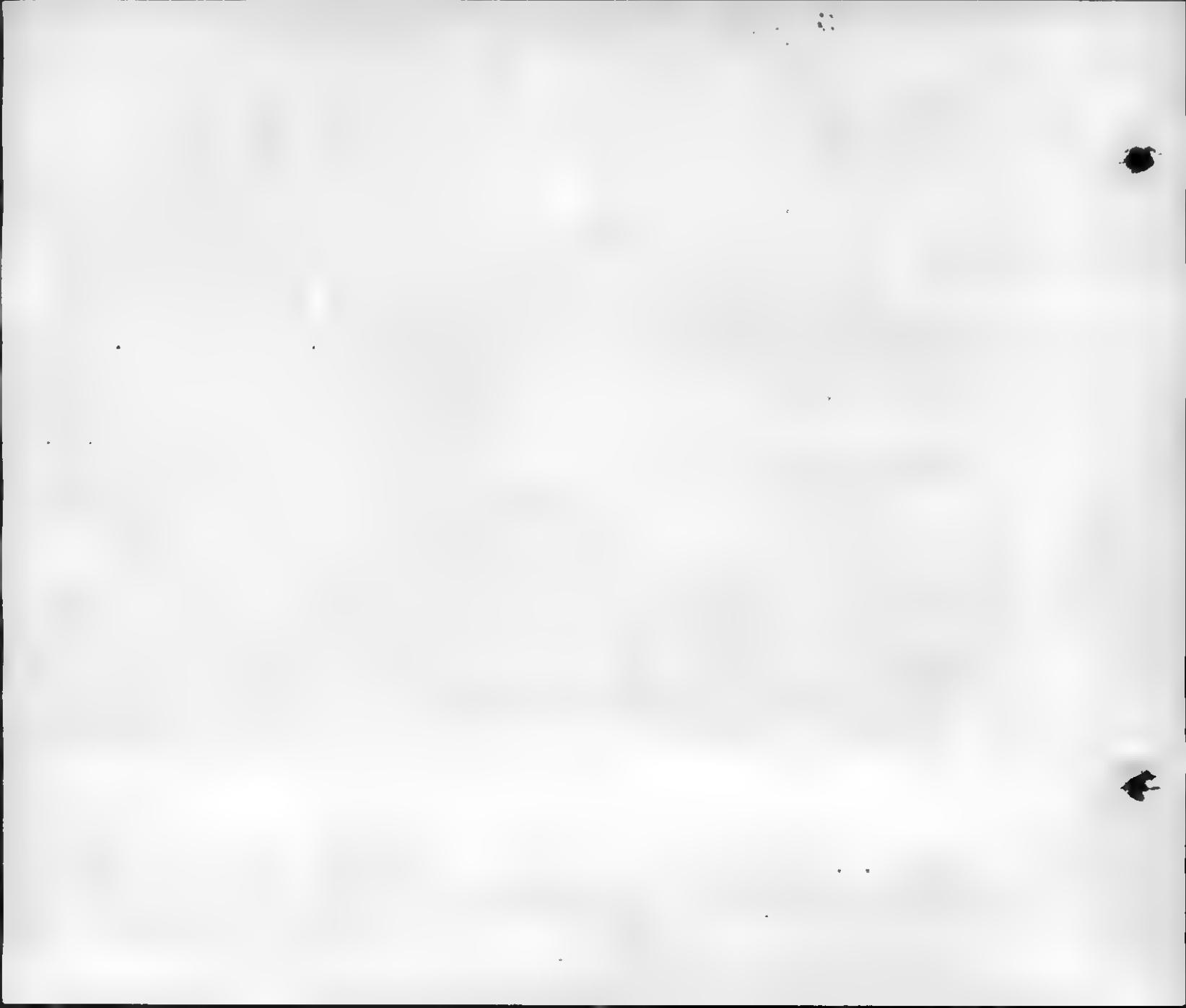
M

4718

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with Form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2 '57

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10 months					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 37 Browning St.		d. STREET ADDRESS 37 Browning St.					
e. NAME OF DECEASED (Type or print) First Welty		f. MIDDLE NAME Weidner					
g. SEX male		h. COLOR OR RACE white					
i. MARRIED WIDOWED		j. NEVER MARRIED DIVORCED					
k. DATE OF BIRTH Oct. 31-1889		l. AGE IN YEARS (last birthday) 68 yrs					
m. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Electric Crane Operator		n. KIND OF BUSINESS OR INDUSTRY Town Creek, Md.					
o. PARENT'S NAME Denton B. Bucy		p. MOTHER'S MAIDEN NAME Mary Huff					
q. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		r. SOCIAL SECURITY NO 276-10-1211(sister)					
s. INFORMANT Grace A. Wolford, Cumberland, Md.		t. ADDRESS Cumberland, Md.					
u. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) you.		v. INFORMANT Coronary occlusion					
w. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b), STATING THE UNDERLYING CAUSE (a). DUE TO Coronary sclerosis		x. DUE TO ?					
y. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) z. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				aa. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		bb. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
cc. TIME OF INJURY Hour a. m. p. m. 19		dd. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		ee. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		ff. (City or town) (County) (State)	
gg. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
hh. ACTUAL SIGNATURE <i>H. V. Deming M.D.</i>		ii. EXAMINER'S NAME (Type) H. V. Deming M.D.		jj. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		kk. DATE SIGNED April 23-1958	
ll. BURIAL, CREMATION, REMOVAL (Specify) Burial		mm. DATE THEREOF May 1, 1958		nn. NAME OF CEMETERY OR CREMATORIUM Hillcrest Cemetery		oo. LOCATION (City, town, or county) Cumberland, Md. (State)	
pp. FUNERAL DIRECTOR'S SIGNATURE <i>Harvey J. Zeigler</i>		qq. ADDRESS Hyndman, Pa.		rr. REC'D BY REGISTRAR DATE MAY 2 '58		ss. REGISTRAR'S SIGNATURE <i>Joe L. Smith</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4719

CERTIFICATE OF DEATH

04006

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 40 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 37 Boone Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) SARAH M. BUTTS		First	Middle	Last	4. DATE OF DEATH April 15, 1958	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> July 6, 1872	9. AGE (in years from birthday) 85 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Robert D. Noland				14. MOTHER'S MAIDEN NAME Elizabeth J. Moore				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Paul A. Butts		Address Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Cerebral Thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH 12 hrs		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) <i>Arteriosclerosis</i>				16 yrs		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cumberland		(County) Cumberland (State) Md.
21. I certify that I attended the deceased from 3/2/54 , 19, to 4/15/58 , 19, that I last saw the deceased alive on 4/15/58 , 19, and that death occurred at Cumberland , M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland								DATE SIGNED 4/16/58
ACTUAL SIGNATURE <i>B. Kight</i>		PHYSICIAN'S NAME (Type) Hill Crest Cemetery						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/1958		22c. NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE <i>Albright</i>		

RECEIVED
MAY 28 1958

APR 21 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04007

4020

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		d. STREET ADDRESS 903 MARYLAND AVE.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LORENZO	Middle Hazel	Last CHAMBERS
4. DATE OF DEATH	Month April	Day 8	Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Mar. 28, 1888
9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Policeman		10b. KIND OF BUSINESS OR INDUSTRY Cumb. Police Dept.	
10c. BIRTHPLACE (State or foreign country) Oakdale, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME LORENZO D. CHAMBERS		14. MOTHER'S MAIDEN NAME Rachael WILLIAMS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO None	
17. INFORMANT George K. Chambers		Address Paw Paw, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 400.1 DUE TO <i>Coronary occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO <i>Ganglionic intensio</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March</i> , 19 <i>58</i> , to <i>April 8</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>April 8</i> , 19 <i>58</i> , and that death occurred at <i>1:25 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>George M. Simons</i> M.D. ADDRESS (Street, city or town, state) <i>128 Belmont St</i> DATE SIGNED <i>4/9/58</i>			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/11/58	
22c. NAME OF CEMETERY OR CREMATORIUM Rice Cemetery		22d. LOCATION (City, town, or county) (State) Williams Rd. near Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR APR 14 '58		24b. REGISTRAR'S SIGNATURE	
DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of the death.

VS A15 (4)
15M 10/57

W. V.

APR 12 1972

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: This law requires that the death certificate be executed within 24 hours after death.

To Funeral Director: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for use as a burial transit permit.

VS A15C L-5 10M -

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04008

CERTIFICATE OF DEATH

Reg. Dist. No.....

4098

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	Allegany Cresaptown	MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	Maryland Allegany Cresaptown (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	28 years		SUBDIVISION STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)	(First) Loretta	(Middle) May	(Last) Corley	4. DATE OF DEATH April 1 1958
SEX Female	COLOR OR RACE White	SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	DATE OF BIRTH Nov. 8, 1874	AGE last birthday 83 yrs. IF UNDER 1 YEAR Months Deys Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Celanese		KIND OF BUSINESS OR INDUSTRY Celanese	BIRTHPLACE (State or foreign country) Buffalo Mills, Pa.	CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John W. Stouffer		14. MOTHER'S MAIDEN NAME Mary Wolford		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. 214-07-3544		17. INFORMANT & ADDRESS Paul Corley, Cresaptown, Md.	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		
IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		Cerebral Arteriosclerosis General arteriosclerosis Diseases of heart and blood vessels		
		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.				
SIGNATURE <i>Allen C. Stouffer</i>		ADDRESS (Street, city, town, state) 59 Green St Leucobard, Md 4/2/58		
DATE SIGNED				
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Apr. 3, 1958	NAME OF CEMETERY OR CREMATORIAL Lybarger Cemetery	LOCATION (City, town, or county) Buffalo Mills, Pa. (State)
24. REC'D BY REGISTRAR APR 7 '58		REGISTRAR'S SIGNATURE <i>W. C. Stouffer</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Harvey L. Seigh, Hyndman, Pa.	
DATE				

8 A 1100

2 2 ddt

100 100 100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04009

Reg. Dist. No.

4021

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN b 4 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CUMBERLAND	
3. NAME OF DECEASED (Type or print) JAMES EARL CROSTEN		4. DATE OF DEATH APRIL 4 1958	Month Day Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 6, 1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Former tire builder		10b. KIND OF BUSINESS OR INDUSTRY Kelly-Tire Co.	11. BIRTHPLACE (State or foreign country) PARSONS, W.VA.
13. FATHER'S NAME JOHN W. CROSTEN		14. MOTHER'S MAIDEN NAME MARY Elizabeth Lee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO. 217-10-1340	17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Injury	
20c. TIME OF INJURY Month, Day, Year Hour o. m. ~ 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) -
20f. (City or town) -		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:45 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Weissman		ADDRESS (Street, city or town, state) 59 State Street, Cumberland, Maryland	
22a. BURIAL/CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 4/7/58	22c. NAME OF CEMETERY OR CREMATORIUM Rest Lawn Memorial Gardens
22d. LOCATION (City, town, or county) Cumberland, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Md.		24a. REC'D BY REGISTRAR APR 8 '58	24b. REGISTRAR'S SIGNATURE John Schubert

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
APR 5 1968

DEAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4122

CERTIFICATE OF DEATH

04010

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 34 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 203 PENNSYLVANIA AVE.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
II. NAME OF DECEASED (Type or print)		First WILLIAM	Middle T.	Last CROSTON	4. DATE OF DEATH APRIL	Month 4	Day 1958	Year			
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 7/24/01	8. AGE (In years last birthday) 50 yr.	9. IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician		10b. KIND OF BUSINESS OR INDUSTRY self Employed		11. BIRTHPLACE (State or foreign country) MARYLAND, Cumberland		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME WILLIAM CROSTON (DECEASED)		14. MOTHER'S MAIDEN NAME MARY ZILER (DECEASED)									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO None		17. INFORMANT PT'S CHART		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>to</i>		DUE TO <i>chronic Myoclonus with Decomposition 2 years</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>to</i>		DUE TO <i>(c)</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) 16 Greene St., Cumberland, MD.		20f (City or town) 16 GREENE ST., CUMBERLAND, MD.		(County) CUMBERLAND		(State) MARYLAND	
21. I certify that I attended the deceased from April 4, 1958 , to April 4, 1958 , that I last saw the deceased alive on April 4, 1958 , and that death occurred at 11:25 P.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE <i>JAMES T. JOHNSON, JR., M.D.</i>		ADDRESS (Street, city or town, state) 16 GREENE ST., CUMBERLAND, MD.									
PHYSICIAN'S NAME (Type) JAMES T. JOHNSON, JR., M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-7-58		22c. NAME OF CEMETERY OR CREMATORIAL St. Mary Cem.		22d. LOCATION (City, town, or county) Cumberland Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli Cumberland, Md.		ADDRESS James F. Scarpelli Cumberland, Md.		24a. REC'D BY REGISTRAR DATE APR 9 '58		24b. REGISTRAR'S SIGNATURE <i>Alv. Schuch</i>					

BUREAU V.E.D.

PR 9 1958

D.E.GEI.V.E.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04012

Reg. Dist. No.

4024

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6 days		b. COUNTY Allegany	
d. NAME OF HOSPITAL (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED (Type or print) Leonard L. Davis		First	Middle	Last	4. DATE OF DEATH April 24, 1899
5. SEX Male		COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 24, 1899	8. AGE (In years last birthday) 58 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY B&O R.R.		9. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
13. FATHER'S NAME Jefferson Davis		11. BIRTHPLACE (State or foreign country) W.Va.—Newberg		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or date of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Leonard L. Davis, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO (c)		Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
		acute myocarditis		6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-6- , 19 58 , to 4-12- , 19 58 , that I last saw the deceased alive on 4-11- , 19 58 , and that death occurred at 6:45A.M. from the causes and on the date stated above				ADDRESS (Street, city or town, state) 576 Greene St. Cumberland, Md.	
ACTUAL SIGNATURE <i>L. Davis</i>				DATE SIGNED 4-12-58	
PHYSICIAN'S NAME (Type) James F. Scarpelli					
22a. BURIAL, CREMAT. ON REMOVAL (Specify) Burial		22b. DATE THEREOF 4-15-58		22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery	
22d. LOCATION (City, town, or county) Cumberland, Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 16 '58	
				24b. REGISTRAR'S SIGNATURE <i>Lil. - educh</i>	

BUREAU V. S.

APR 16 1958

CONFIDENTIAL

FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4025 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04013

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 19 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. at Sacred Heart Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Cumberland	
f. STREET ADDRESS Rt. Bowman's Addition		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lloyd		First Solomon	Middle Diehl
4. DATE OF DEATH April 27 1953		Month April	Day 27
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH June 9-1398		9. AGE (In years, last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) near Buffalo Mills, Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel Diehl	
14. MOTHER'S MAIDEN NAME Ida Hyde		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no, or unknown) no	
16. SOCIAL SECURITY NO (If yes, give nos. or dates of service) 214-05-7616 Cards in card case		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] Coronary occlusion			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary sclerosis			
DUE TO (c) Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED April 28-1958	
EXAMINER'S NAME (Type) H. V. Deming M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF April 30, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Dry Ridge Cemetery	
22d. LOCATION (City, town, or county) Nr. Manns Choice, Pennsylvania		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS m	24a. REC'D BY REGISTRAR DATE MAY 1 '58
		24b. REGISTRAR'S SIGNATURE Alfred J. Hafer	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4726

CERTIFICATE OF DEATH

04014

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c LENGTH OF STAY IN 1b 61 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d STREET ADDRESS 318 Grand Ave.			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 318 Grand Ave.				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) Hubert		First	Middle M.	Last Donohoe	4. DATE OF DEATH Apr. 23 1958	Month Apr.	Day 23	Year 1958	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1873	9. AGE (In years last birthday) 85 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Rawlings, Md.		12 CITIZEN OF WHAT COUNTRY: USA			
13. FATHER'S NAME Coleman Donohoe				14. MOTHER'S MAIDEN NAME Mary Healy					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 705-07-6834		17. INFORMANT Mrs. Hubert Donohoe, Cumberland, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH Acute									
4/23/58 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Myocarditis & Decompensation - 2 yrs									
DUE TO (c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. Apr. 23, 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cumberland		(County) Calvert	(State) Md.
21. I certify that I attended the deceased from Apr. 15, 1958 , to Apr. 23, 1958 , that I last saw the deceased alive on Apr. 23, 1958 , and that death occurred at 1 P.M. , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) Cumberland, Md. 21201									
DATE SIGNED May 1, 1958									
ACTUAL SIGNATURE Elmer J. Garrett		NAME (Type) M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 26, 1958		22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS		24a. REG'D BY REGISTRAR DATE APR 28 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith			

BUREAU V. S.

APR 22 1963

REFILE

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

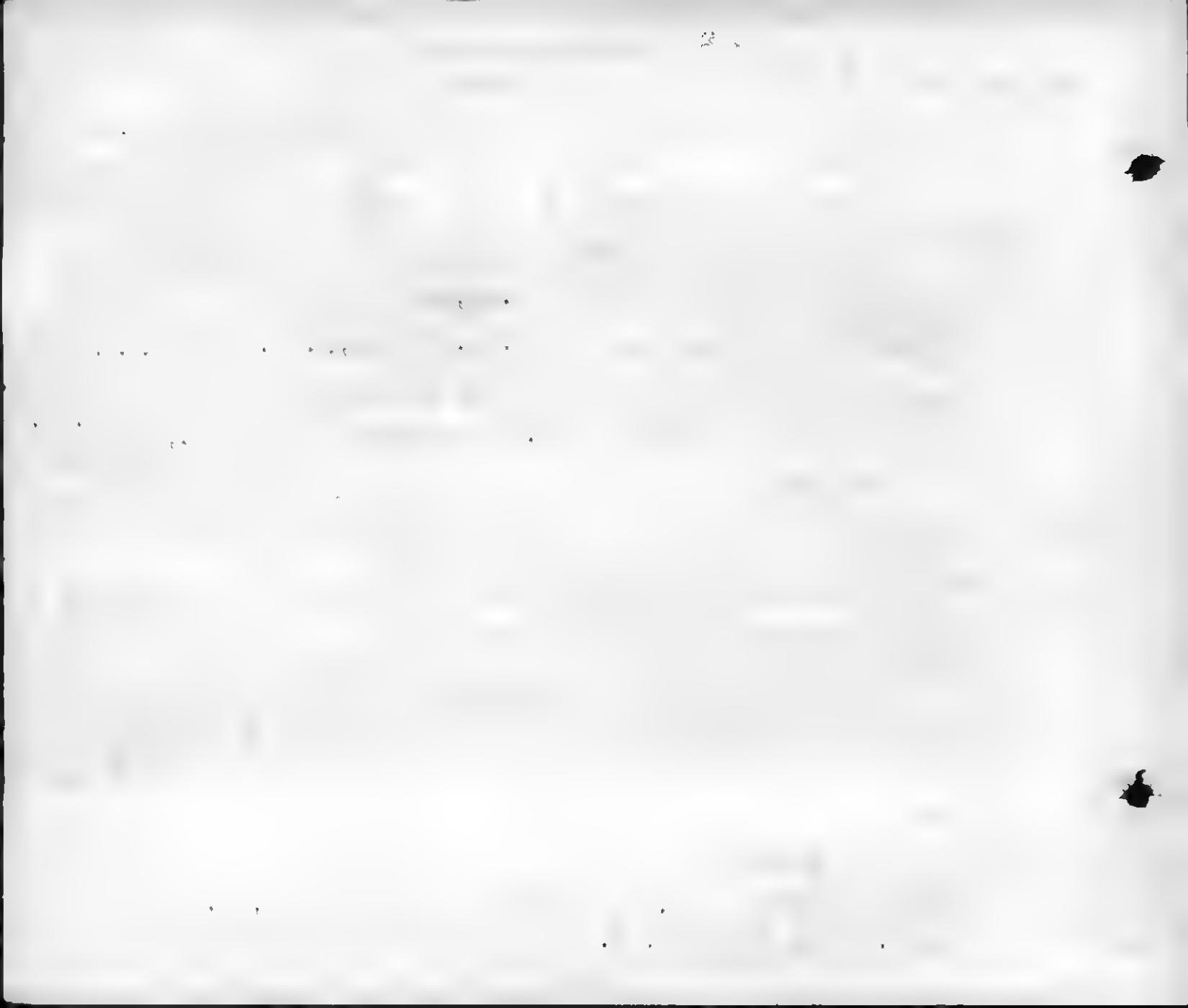
04015

CERTIFICATE OF DEATH

Reg. Dist. No.

4027

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE West Virginia		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 1 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgeley		TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS 160 Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Beaurie	First	Middle Marie	Lost	4. DATE OF DEATH Dougherty	Month 4	Day 26	Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1894	9. AGE (in years lost birthday) 63 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) W. Va. Junction, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Dougherty		14. MOTHER'S MAIDEN NAME Adelia Mullen		Address W. Va. Junction, W. Va., 162 Main St., Ridgeley,				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Ursula Dougherty		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Inseme		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteritis</i>		DUE TO (c) <i>Bleeding Arteries</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour o. m p. m	Month 19	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Lebanon	(County) Lebanon Co.	(State) Penn.		
21. I certify that I attended the deceased from 2/22/58 , to 4/26/58 , that I last saw the deceased alive on 4/26/58 , and that death occurred at 11:51 A.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) Lebanon, Lebanon Co., Penn. DATE SIGNED 4/26/58								
ACTUAL SIGNATURE L. Ley		M.D.						
PHYSICIAN'S NAME (Type) Dr. Leo Ley								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/58		22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR MM 1 '58		24b. REGISTRAR'S SIGNATURE Alberici		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4-28

CERTIFICATE OF DEATH

Reg. Dist. No.

04016

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOHN	Middle H.	Last Dwyer
4. DATE OF DEATH APRIL 13 1958	Month Day Year		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1/17, -1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY RETIRED (Store)	
11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME JAMES H. Dwyer		14. MOTHER'S MAIDEN NAME ADA SPRINKLE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or date of service) No		16. SOCIAL SECURITY NO. 212 32 8061	
17. INFORMANT NEICE LIBBY ROBERTSON		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Chronic Myocarditis with Decongestant Toxicity Chronic Myocarditis 8 years			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4-6-1958		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-6-1958 to 4-13-1958 and that I last saw the deceased alive on 4-13-1958 , and that death occurred on 4-13-1958 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE D. Johnson		ADDRESS (Street, city or town, state) 16 Green St Cumberland, Md.	
PHYSICIAN'S NAME (Type) Byron Kight		DATE SIGNED 4-15-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/1958	
22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland - Md.	
		24a. REC'D BY REGISTRAR DATE APR 18 '58	
		24b. REGISTRAR'S SIGNATURE DeLoach	

BUREAU V. S.
PARIS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4083 CERTIFICATE OF DEATH

04017

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		b. COUNTY Allegany		
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS HOSPITAL		d. STREET ADDRESS Detmold Street		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First MARTHA	Middle D.	Last EICHHORN	
4. DATE OF DEATH	Month 4/9/1958		Day Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 8th, 1882	
9. AGE (In years last birthday) 76 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework Own Home	11. BIRTHPLACE (State or foreign country) Nikep, MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Donaldson	14. MOTHER'S MAIDEN NAME Catherine Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO	16. SOCIAL SECURITY NO NONE	17. INFORMANT MARTIN EICHHORN, LONACONING, MD.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pyelonephritis (SON) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic cystitis DUE TO (c)				
INTERVAL BETWEEN ONSET AND DEATH 7 days				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Arteriosclerosis				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) MAIN ST	(County) MD.	(State) MD.
21. I certify that I attended the deceased from Mar. 31, 1958 , to April 9, 1958 , that I last saw the deceased alive on April 9, 1958 , and that death occurred at 11 p.m. M, from the causes and on the date stated above.				
ACTUAL SIGNATURE Leslie R. Miles Jr.				ADDRESS (Street, city or town, state) MAIN ST
DATE SIGNED 4-11-58				
PHYSICIAN'S NAME (Type) LESLIE R. MILES JR LONACONING				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/12/1958	22c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery	22d. LOCATION (City, town, or county) Lonaconing, MD.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN, LONACONING, MD.	ADDRESS	24a. REC'D BY REGISTRAR DATE APR 14 '58	24b. REGISTRAR'S SIGNATURE John Eichhorn	

PERLAU V. S
R. 12. 1968
ס. ג. ו. ו. ק. ה.

-MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4-99

CERTIFICATE OF DEATH

04018

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Vale		c. LENGTH OF STAY IN lb years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Vale					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Park Heights		d. STREET ADDRESS Park Heights		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) BENJAMIN		First NEAL	Middle ELLSWORTH	Lost	4. DATE OF DEATH April 22	Month Month	Day Day	Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1873	9. AGE (In years lost birthday) yrs. 85	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Painter		11. BIRTHPLACE (State or foreign country) Mansfield, Ohio		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Samuel Ellsworth		14. MOTHER'S MAIDEN NAME Eliza Funk							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Park Heights Lawrence Ellsworth, La Vale, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertension, Precipitated by exertion</i> - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <i>Vascular degeneration</i>		INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? NO									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cumberland		(County) Maryland	(State) Maryland
21. I certify that I attended the deceased from 4/17/58 19 to 4/22/58 19, that I last saw the deceased alive on 4/22/58 19, and that death occurred at 10 AM from the causes and on the date stated above ACTUAL SIGNATURE <i>L.B. Mathews</i> ADDRESS (Street, city or town, state) Cumberland, Maryland DATE SIGNED 4/22/58									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 25, 1958		22c. NAME OF CEMETERY OR CREMATORIUM St. Peters & Pauls Cath. Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE AP 23 58		24b. REGISTRAR'S SIGNATURE <i>John J. Hafer</i>			

REGEV V. S

APR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64019

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be given to the funeral-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		4100 Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) b. STATE Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		La Vale		c. LENGTH OF STAY IN lb 13 yrs		d. STREET ADDRESS 525 National Highway		d. STREET ADDRESS 525 National Highway	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 525 National Highway									
3. NAME OF DECEASED (Type or print) Dr. Lysle		First Rogers		Middle Everhart		4. DATE OF DEATH April 21 1958		Month Day Year	
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH July 20-1897		9. AGE (In years less than half生日) 60 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practice of medicine*		10b. KIND OF BUSINESS OR INDUSTRY Physician		11. BIRTHPLACE (State or foreign country) Keyser, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME Clarence L. Everhart		14. MOTHER'S MAIDEN NAME Birdie Rogers							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO none		17. INFORMANT (wife) Margaret Everhart, LaVale, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Coronary sclerosis				?	
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>H. V. Deming M.D.</i>				M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 22-1958		DATE SIGNED	
22a. BURIAL CREMATION: REMOVAL (Specify)		22b. DATE THEREOF Burial 7/24/58		22c. NAME OF CEMETERY OR CREMATORIAL Queen's Point Cem		22d. LOCATION (City, town, or county) Keyser W Va.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Louis Stein Inc. Cuad. M &		24a. REC'D BY REGISTRAR APR 24 '58		24b. REGISTRAR'S SIGNATURE Albert E. Deuch			

DECEMBER

APR 2

DECEMBER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04020

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission.) a. STATE Md. b. COUNTY Garrett				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Adam	Middle Willard	Last Fazenbaker	4. DATE OF DEATH April 11 1958	Month	Day	Year
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15-1913	9. AGE (In years from birthday) 44 yrs	IF UNDER 14 YEARS	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done, even if retired) Laborer - Hazelwood Construction Co.		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Accident, Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Noah Fazenbaker				14. MOTHER'S MAIDEN NAME Sally Bird				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. 212-14-7794 (wife) & Sacred Heart Hospital records 17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Atelectasis & ruptured liver. (c) DUE TO Automobile accident				(right) INTERVAL BETWEEN ONSET AND DEATH 2 days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Forced off of road, auto hit a concrete bridge.						
20c. TIME OF INJURY Month, Day, Year Hour 9.10 P.M. April 9 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pt. #36 near		20f. (City or town) Mt. Savage, Allegany, Md.	(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>				MD CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED April 11-1958				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/14/58		22c. NAME OF CEMETERY OR CREMATORIUM BETHESDA		22d. LOCATION (City, town, or county) Bel Air, Garrett Co. Mo. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Don J. Neuman, Brantville, Md.</i>				ADDRESS		24a. REC'D BY REGISTRAR/ DATE APR 15 '58	24b. REGISTRAR'S SIGNATURE <i>Outreach</i>	

BUREAU N.Y.

PP 17 1959

POLICE DEPARTMENT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4730

CERTIFICATE OF DEATH

04021

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 3/18/58		b. COUNTY		Allegany		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				
3. NAME OF DECEASED (Type or print)		First Mildred	Middle Ethel	Last Fisher	4. DATE OF DEATH	Month April	Day 7,	Year 19 58
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/7/1896	9. AGE (In years last birthday) 61 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Office Worker		10b. KIND OF BUSINESS OR INDUSTRY Appliance Store		11. BIRTHPLACE (State or foreign country) Brunswick, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Cyrus Fisher				14. MOTHER'S MAIDEN NAME Laura V. Barger				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 214-05-5199		17. INFORMANT P. O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records				
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY <i>Cerebral Hemorrhage</i> <i>C. Hemiplegia</i> INTERVAL BETWEEN ONSET AND DEATH</p> <p>IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>C. Hemiplegia</i></p> <p>DUE TO <i>Rt. side</i></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio-Sclerosis cerebral and</i> (c) <i>General Hypertension</i></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 49 Greene St.	(County)	(State)
<p>21. I certify that I attended the deceased from <u>3/18/58</u>, 19, to <u>4/7/58</u>, 19, that I last saw the deceased alive on <u>4/7/58</u>, 19, and that death occurred at <u>4:55 A.M.</u> from the causes and on the date stated above.</p> <p>ACTUAL SIGNATURE <u>W. Lee B. Mathews</u> ADDRESS (Street, city or town, state) <u>49 Greene St.</u> DATE SIGNED <u>4/7/58</u></p>								
PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		Cumberland, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-9-1958		22c. NAME OF CEMETERY OR CREMATORIUM Greenmount Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS		24a. REG'D BY REGISTRAR APR 10 1958		24b. REGISTRAR'S SIGNATURE <u>Lee B. Mathews</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BESTIAL V. 2

8 2000

L
L
L

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4031

CERTIFICATE OF DEATH

04022

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W. Va.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		b. COUNTY Morgan	
c. LENGTH OF STAY IN 1b 2 wks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Paw Paw, W. Va.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Archie	Middle Vanmeter	Last Foltz
4. DATE OF DEATH April 22, 1958	Month 8	Day 22	Year 1958
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Mar. 29, 1908
8. AGE (In years last birthday) 50 yrs	9. IF UNDER 1 YEAR Months 9	10. IF UNDER 24 HRS. Days 9	11. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Orchard	
11. BIRTHPLACE (State or foreign country) Hardy County, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Foltz		14. MOTHER'S MAIDEN NAME Lizzie Funkhouser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 232-10-2514	
17. INFORMANT Bonnie S. Foltz, Paw Paw, W. Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Urenia		INTERVAL BETWEEN ONSET AND DEATH 4 months	
445 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Malignant Hypertension		9 months	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-17 , 19 57 , to 4-8 , 19 58 , that I last saw the deceased alive on 4-7 , 19 58 , and that death occurred at 2:00 AM , from the causes and on the date stated above. ACTUAL SIGNATURE R. W. Ballin		ADDRESS (Street, city or town, state) 62 Greene Street	
PHYSICIAN'S NAME (Type) R. W. Ballin, M. D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/10/58	
22c. NAME OF CEMETERY OR CREMATORIUM Woodrow Church Cem.		22d. LOCATION (City, town, or county) (State) Paw Paw, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Wade J. Ballin		24a. REC'D BY REGISTRAR DATE APR 17 '58	
ADDRESS Berkeley Springs, W. Va.		24b. REGISTRAR'S SIGNATURE Q. E. Johnson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BUREAU K.

PR 17 1959

CONFIDENTIAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4032

CERTIFICATE OF DEATH

Reg. Dist. No.

04023

1. PLACE OF DEATH o COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2HRS. 35MINS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS Church Hill		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First JOHN	Middle FRANCIS	Last GALLAGHER SR.	4. DATE OF DEATH APRIL	Month	Day 4	Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 14 1887	9. AGE (In years last birthday) 70 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sec. & Treas Water Co.		10b. KIND OF BUSINESS OR INDUSTRY Mt. Savage Water Co.		11. BIRTHPLACE (State or foreign country) MT. SAVAGE, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. AMERICA		
13. FATHER'S NAME PATRICK GALLAHER				14. MOTHER'S MAIDEN NAME Adelaide STEPHENS				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO A-540 207		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 hrs. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Sudden Coronary Thrombosis Coronary Artery Disease INTERVAL BETWEEN ONSET AND DEATH 1949								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Mount Savage	(County) Montgomery	(State) Maryland
21. I certify that I attended the deceased from Jan 10 1958 to Jan 14 1958 , that I last saw the deceased alive on Jan 14 1958 , and that death occurred at 3:45 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE W. F. Williams M.D.				ADDRESS (Street, city or town, state) 122 So. Centre St.				DATE SIGNED 1958
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/7/58		22c. NAME OF CEMETERY OR CREMATORIUM St. Patrick's Cemetery		22d. LOCATION (City, town, or county) Mount Savage, Maryland		(State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Md.				ADDRESS		24a. REC'D BY REGISTRAR April 6 '58	24b. REGISTRAR'S SIGNATURE Oldenrich	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS ATS (4)
15M 10/57

PEAU V.

PR A 153

GEIWEDE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04024

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural* Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 107 Mary St.		d. STREET ADDRESS R.F.D. #5 Locust Grove	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Louis		First Louis	Middle Albert
4. DATE OF DEATH April 19 1958		Month April	Day 19
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Dec. 16 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carman		10b. KIND OF BUSINESS OR INDUSTRY B&O R.R.	
11. BIRTHPLACE (State or foreign country) Bedford Co., Pa,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Garlick		14. MOTHER'S MAIDEN NAME Eva Price	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Y		16. SOCIAL SECURITY NO. 111-11-1111	
17. INFORMANT Susan Pryor-Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary occlusion DUE TO (c) Coronary sclerosis with angina syndrome		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis		1 yr	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		?	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) White at work	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 20-1958	
EXAMINER'S NAME (Type) H. V. Deming M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/58	
22c. NAME OF CEMETERY, OR CREMATORIAL St. Luke's Cem.		22d. LOCATION (City, town, or county) Cumberland	
23. FUNERAL DIRECTOR'S SIGNATURE Lewis Star Inc. Cumb M &		ADDRESS	24a. REC'D BY REGISTRAR DATE APR 22 '58
			24b. REGISTRAR'S SIGNATURE John Smith

RECEIVED
APR 1 1968

RECEIVED
APR 1 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4034 CERTIFICATE OF DEATH

Reg. Dist. No. 04025

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND Rt. # 3					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS Bedford Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) CHARLES T. GILLUM		First	Middle	Last	4. DATE OF DEATH APRIL 19	Month	Day	Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH MAY 23, 1903	9. AGE (In years lost, birthday) yrs. 54	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Traffic Dept.		10b. KIND OF BUSINESS OR INDUSTRY CELANESE Corp.		11. BIRTHPLACE (State or foreign country) BEDFORD, Co., Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME DUNCAN GILLUM		14. MOTHER'S MAIDEN NAME BARBARA James		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-3508			17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Physical Failure		INTERVAL BETWEEN ONSET AND DEATH 10 days			
		DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Coronary Disease					
		DUE TO							
		(c)							
19. MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bedford Rd. near Centerville, Pa.		20f. (City or town) Centerville		(County) Washington (State) Pa.	
21. I certify that I attended the deceased from April 18, 1958 , to April 19, 1958 , that I last saw the deceased alive on April 18, 1958 , and that death occurred at 12:25 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Centerville, Washington Co., Pa.		DATE SIGNED 4/21/58	
ACTUAL SIGNATURE W. Wayne George		PHYSICIAN'S NAME (Type) DR. JAMES							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/21/58		22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery		22d. LOCATION (City, town, or county) Bedford Rd. near Centerville, Pa.		(State) Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE APR 23 '58		24b. REGISTRAR'S SIGNATURE W. Wayne George			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU N.Y.

APR 21 1968

DEPARTMENT OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04026

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of the death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.
FUNERAL DIRECTOR: Note: Page 3 should be used as a burial-permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		4035 Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cumberland		c. LENGTH OF STAY IN TB 5 weeks		d. STATE W.Va. b. COUNTY Mineral						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Sacred Heart Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Ridgely						
3. NAME OF DECEASED (Type or print)		First Mary	Middle Ann	Last Goodrich	4. DATE OF DEATH April	Month 7	Day Year 1958					
5. SEX female		6. COLOR OR RACE white		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 28-1887	9. AGE (in years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months Days Hours M.M.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?						
Retired-Registered nurse		Nursing		Mt. Savage, Md.		U.S.A.						
13. FATHER'S NAME Andrew Goodrich		14. MOTHER'S MAIDEN NAME Jane Wilson		Address								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-30-8472		17. INFORMANT Scared Heart Hospital records.		INTERVAL BETWEEN ONSET AND DEATH 5 weeks						
No												
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Traumatic shock due to fractured right radius and surgical neck of right femur. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Also had myocarditis, generalized arterio-sclerosis, multiple furunculosis and varicose veins of both legs. DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour 1 p.m. 3-4 19 58				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sidewalk	20f. (City or town) Cumberland, Allegany, Md.	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 8-1958		DATE SIGNED								
EXAMINER'S NAME (Type) H.V. Deming M.D.												
22a. BURIAL CREMATION, DATE THEREOF REMOVAL (Specify) Burial 4/10/58		22b. NAME OF CEMETERY OR CREMATORY St. George Episcopat Cemetery		22d. LOCATION (City, town, or county) Mt Savage Maryland		(State)						
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox Cumberland, Maryland		ADDRESS		24c. REC'D BY REGISTRAR		24d. REGISTRAR'S SIGNATURE <i>Ruth E. Silcox</i>						
						DATE APR 11 '58						

סְנָאָתָן

סְנָאָתָן

סְנָאָתָן

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4^84

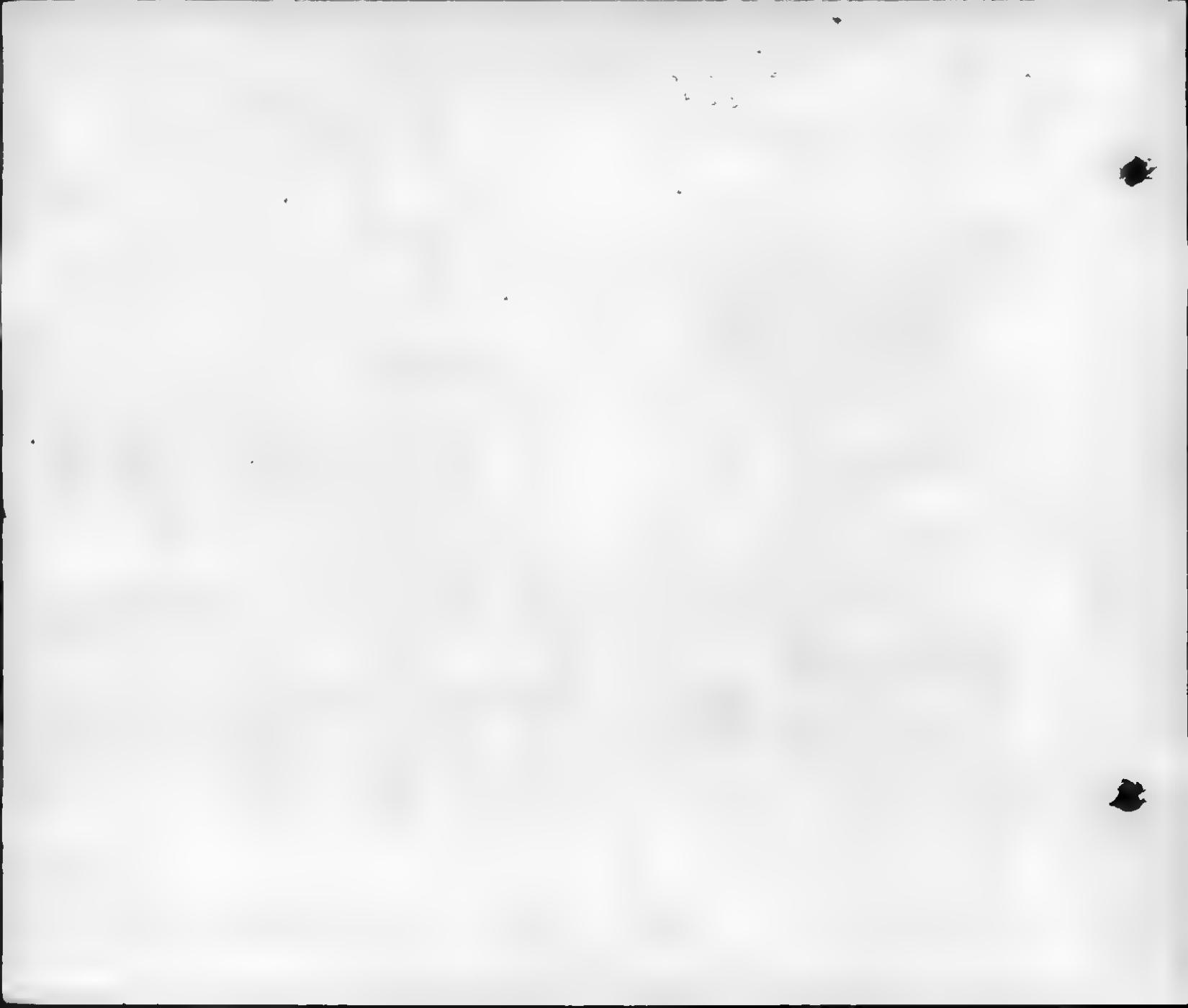
CERTIFICATE OF DEATH

Reg. Dist. No.

04027

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b RURAL and give nearest town		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		d. STREET ADDRESS 301 Maryland Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 301 Maryland Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ida	Middle M	Last Greitzner	4. DATE OF DEATH Nov. 20, 1884	Month April	Day 26	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1884	9. AGE (In years last birthday) 73 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Gwynn				14. MOTHER'S MAIDEN NAME Harriet Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT Rexroad Brooks		Address 301 Md. Ave. Westernport, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Degeneration Not Specified as Rheumatic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 2 Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute gastro-enteritis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 22, 1958 , to April 26, 1958 , that I last saw the deceased alive on April 25, 1958 , and that death occurred at 5:40 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Paula Wilson M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) Piedmont, W. Va. DATE SIGNED 4-28-58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 29, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Philos		22d. LOCATION (City, town, or county) Westernport (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. Brink - Westernport, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 1 '58		24b. REGISTRAR'S SIGNATURE A. Lewis	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4936

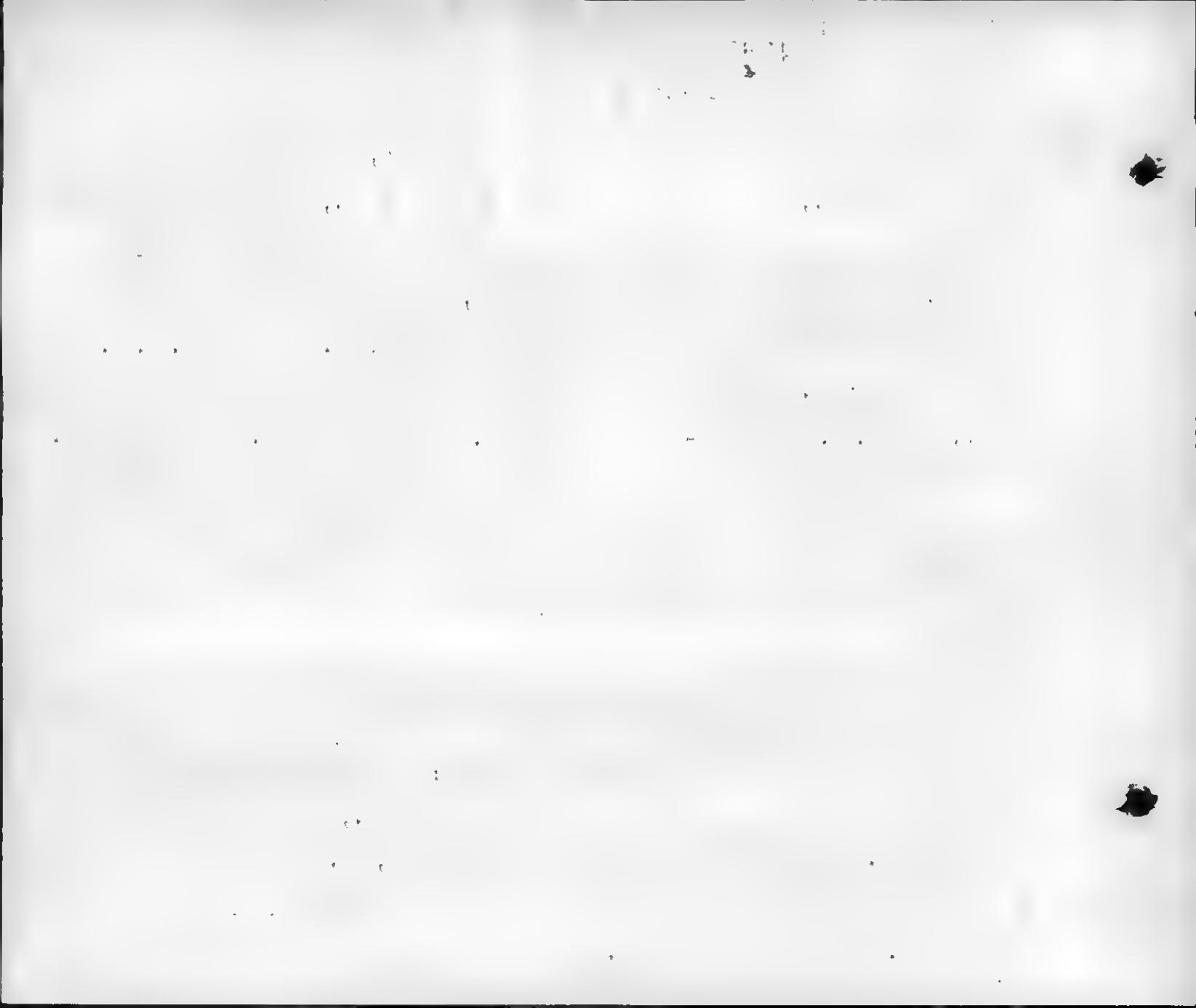
CERTIFICATE OF DEATH

Reg. Dist. No. 04028

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland ,		d. STREET ADDRESS 408 Lehigh St.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 408 Lehigh St.,				d. STREET ADDRESS 408 Lehigh St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EARL		First	Middle NOAH	Last HAGER	4. DATE OF DEATH April	Month 28,	Doy 19	Year 58	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1895	9. AGE (In years lost, birthday) 62	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bottling House Foreman		10b. KIND OF BUSINESS OR INDUSTRY Queen City Brewery		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Martin H. Hager		14. MOTHER'S MAIDEN NAME Bertha Long							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes,		16. SOCIAL SECURITY NO W. W. J. 1		17. INFORMANT Joseph M. Hager		Address 305 Polk St., Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 6 months							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Cancer of the right lung</i>							
163X DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)									
DUE TO (c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) 57 Greene St.,		(State)	
21. I certify that I attended the deceased from 1-18-1958 to 4-27-1958 , that I last saw the deceased alive on 4-27-1958 , and that death occurred at 12:50 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 57 Greene St.,		DATE SIGNED 4/30/58							
ACTUAL SIGNATURE <i>L Brings</i>									
PHYSICIAN'S NAME (Type) Dr. Lewis Brings		Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/1/58		22c. NAME OF CEMETERY OR CREMATORIUM Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE JUN 2 '58		24b. REGISTRAR'S SIGNATURE <i>A. L. Smith</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4-37

CERTIFICATE OF DEATH

04029

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS 180 Wineow Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First James	Middle W.	Last Hamilton	4. DATE OF DEATH April 16 1958	Month April	Day 16	Year 1958
5. SEX Male	6. COLOR OR RACE Color	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/58	9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME James Hamilton				14. MOTHER'S MAIDEN NAME Delina Rhodes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Chart		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 49UX DUE TO <i>Pneumonia, bilateral</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/14 , 1958, to 4/16 , 1958, that I last saw the deceased alive on 4/16 , 1958, and that death occurred at 3:05 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 456 N. Center Street							
DATE SIGNED 4/17/58							
MEDICAL CERTIFICATION							
ACTUAL SIGNATURE <i>Leroy N. Ley Jr.</i>							
PHYSICIAN'S NAME (Type) Dr. I. H. Ley							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/58		22c. NAME OF CEMETERY OR CREMATORIUM S. S. Peter & Paul Cemetery		22d. LOCATION (City, town, or county) Cumberland Md.	
(State)							
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hager Cumberland Md.							
ADDRESS 180 Wineow Street							
24a. REC'D BY REGISTRAR APP 22 '58							
24b. REGISTRAR'S SIGNATURE Lei. e. leach							

BUREAU Y.

1922 22 1928

GEIYED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04030

Page 10 of 11

GOR STATE
HEALTH DERT

1

every, please
for. None
start your file
record. Had

D) DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director to be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by the funeral director; Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health.

4085				Reg. Dist. No.							
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg 6 days				c. LENGTH OF STAY IN lb X Mt. Savage							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital				e. STREET ADDRESS /							
3. NAME OF DECEASED (Type or print) Edward		First	Middle V.	Last Henckel	4. DATE OF DEATH	Month April	Day 1	Year 19 58			
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> June 28-1875	9. AGE (in years from birthdate) 82 yrs.							
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? Wellersburg, Pa. U.S.A.					
13. FATHER'S NAME Valentine Henckel				14. MOTHER'S MAIDEN NAME Kathryn Snyder							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? [Yes, no, or unknown] no				16. SOCIAL SECURITY NO. 282-05-0756		17. INFORMANT Miners Hospital records.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 403.0 DUE TO Traumatic pneumonitis Conditions, if any, which gave rise to immediate cause (b) a fall (a), stating the underlying cause last. (c) also had arteriosclerosis.				INTERVAL BETWEEN ONSET AND DEATH Gradual 6 days 8 days ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Shaving, lost balance, fell, struck left side of chest against a chair.							
20c. TIME OF INJURY Month, Day, Year Hour 10 March 22 1958 P.M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Mt. Savage, Allegany, Md.		(County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>											
DATE SIGNED April 2-1958											
EXAMINER'S NAME (Type) H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) H.V. Deming M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 4 -58		22c. NAME OF CEMETERY OR CREMATORIUM St. Patricks Cemetery		22d. LOCATION (City, town, or county) Mt. Savage, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J.R. Durst		ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR APR 7 '58		24b. REGISTRAR'S SIGNATURE <i>W. Edwards</i>					

VS. A15M1
5M 2/57

PEACEFUL
85400

SEARCHED

INDEXED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4-38

CERTIFICATE OF DEATH

Reg. Dist. No. 04031

1. PLACE OF DEATH a. COUNTY		Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE		Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Cumberland		6/5/57		Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Allegany County Infirmary		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Allegany County Infirmary				Williams Road			
3. NAME OF DECEASED (Type or print)		First John	Middle Thomas	Last Hodel	4. DATE OF DEATH	Month April	Day 9, Year 1958
5. SEX		6. COLOR OR RACE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Male White WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years (On birthday) 87 yrs)	
			2/14/1871			IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired - Laborer		B.&O. R. R.		Cumberland, Maryland		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Unknown		Mary Ann Hodel					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes No, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
No		None		Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hypertension, Chronic degeneration</i> INTERVAL BETWEEN ONSET AND DEATH 443 X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension & Cardiac Hypertrophy</i> (c) <i>Senility & Arterio Sclerosis</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? DUE TO YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/5/57, 19, to 4/9/58, 19, that I last saw the deceased alive on 4/9/58, 19, and that death occurred at 11:40 P.M. from the causes and on the date stated above		ADDRESS (Street, city or town, state) 49 Green Street DATE SIGNED 4/10/58					
ACTUAL SIGNATURE <i>Dr. Lee B. Mathews</i>							
PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		Cumberland, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-12, 1958		22c. NAME OF CEMETERY OR CREMATORIUM St. Peter & Paul Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR APR 14 '58		24b. REGISTRAR'S SIGNATURE <i>Av. Leach</i>	

ס. ו. י. ד. ו. ו.

ו. ו. ו. ו. ו. ו.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4939

CERTIFICATE OF DEATH

Reg. Dist. No.

04032

1. PLACE OF DEATH a. COUNTY <u>Allegany</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		b. COUNTY <u>Allegany</u>	
c. LENGTH OF STAY IN 1b <u>RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>215 Wallace St</u>		d. STREET ADDRESS <u>215 Wallace St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>John</u>	Middle <u>H.</u>	Last <u>Howard</u>
4. DATE OF DEATH	Month <u>Apr.</u>	Day <u>12</u>	Year <u>1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <u>Oct. 8, 1869</u>
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) <u>88 yrs</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired); <u>Retired Stationery Express, Tanning Co</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>New Orleans</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Unknown</u>	14. MOTHER'S MAIDEN NAME <u>Unknown</u>	Address <u>Mrs. Marion Miles Cumb. Md.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>no</u>	16. SOCIAL SECURITY NO.	17. INFORMANT	INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension, chronic degeneration</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, Senile,</u> (c) <u>Mark Hypotension</u>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 25, 1958</u> to <u>Apr. 12, 1958</u> that I last saw the deceased alive on <u>Apr. 12, 1958</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.			
MEDICAL CERTIFICATION SIGNATURE <u>Lewis Stein Inc.</u>		ADDRESS (Street, city or town, state) <u>49 Greene St</u>	
22a. DATE SIGNED <u>4/14/58</u>		DATE SIGNED <u>4/14/58</u>	
22b. PHYSICIAN'S NAME (Type) <u>Lewis Stein Inc.</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Woodlawn Cem.</u>	
22d. LOCATION (City, town, or county) <u>Cumberland MD</u>		(State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lewis Stein Inc. Cumb. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 13 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Bob Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rejoined to hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURZAU V. S.

IPR 16 1958

100-1000000000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4740

CERTIFICATE OF DEATH

Reg. Dist. No.

04633

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Alleghany		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6 yrs. Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 451 Goethe St.				d. STREET ADDRESS 451 Goethe Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) SALEY		First	Middle	Last	4. DATE OF DEATH 4	Month	Day	Year		
				HUMBERTSON			13	19		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-1862	9. AGE (In years lost birthday) 95 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines		11. BIRTHPLACE (State or foreign country) Shaft, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Wm. Humbertson				14. MOTHER'S MAIDEN NAME Mary Twigg						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
						Emory Perkins, Midland, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic Heart Disease FAIRLY Years DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)										
INTERVAL BETWEEN ONSET AND DEATH										
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from 3/21/48 to 4/13/58 , that I last saw the deceased alive on 4/13/58 , and that death occurred at 4:00 P.M. from the causes and on the date stated above									ADDRESS (Street, city or town, state)	
									DATE SIGNED	
ACTUAL SIGNATURE <i>John B. Davis, M.D.</i>		2 Broadway								
PHYSICIAN'S NAME (Type) <i>John B. Davis, M.D.</i>		Frostburg, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/15/58		22c. NAME OF CEMETERY OR CREMATORIUM Frostburg Memorial Park		22d. LOCATION (City, town, or county) Frostburg, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Benj H. Wentz</i>		ADDRESS afer Funeral Home 13 E. Main, Frostburg, Md.		24a. REC'D BY REGISTRAR APR 17 '58		24b. REGISTRAR'S SIGNATURE <i>D. Research</i>				

BURGESS

APR 17 1969

REGGIE LEE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4041

CERTIFICATE OF DEATH

04034

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Maryland		d. STREET ADDRESS 401 Pennsylvania Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 401 Pennsylvania Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ALICE LOUISA JOHNSON		First	Middle	Last	4. DATE OF DEATH April 22, 1958	Month	Day	Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 8, 1897	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Homd		11. BIRTHPLACE (State or foreign country) Marquess, West Virginia		12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME Charles N. Huffman		14. MOTHER'S MAIDEN NAME Charles Ida Wolfe							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT John T. Johnson		401 Pennsylvania Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 mths	
		<i>Malaria</i> <i>Carcinoma of uterus</i>						<i>4 mon</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) M.D. 236 Va. Ave. Cumberland		(County) W.M.D.	(State) MD
21. I certify that I attended the deceased from Apr. 15, 1958 , to Apr. 22, 1958 , that I last saw the deceased alive on Apr. 16, 1958 , and that death occurred at 11:25 A.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) Evansville, West Virginia	DATE SIGNED 4/24/58
ACTUAL SIGNATURE Clay E. Durrett									
PHYSICIAN'S NAME (Type) Clay E. Durrett, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 25, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Evansville Cemetery		22d. LOCATION (City, town, or county) Evansville, West Virginia		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR APR 28 1958		24b. REGISTRAR'S SIGNATURE B. L. Smith			

BUREAU V. S

RECEIVED
APR 22 1967

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4042 CERTIFICATE OF DEATH

Reg. Dist. No. 04035

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb lyr. 3mo. 2da.	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		d. STREET ADDRESS 142 Mechanic St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Anna	Middle Dorsey	Last Johnson	4. DATE OF DEATH April 27 1958
--	----------------------	-------------------------	------------------------	--

5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH June 23, 1892	9. AGE (In years last birthday) 65 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0
-------------------------	------------------------------------	---	--	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	-----------------------------------	--	--

13. FATHER'S NAME Phillip Dorsey	14. MOTHER'S MAIDEN NAME Elizabeth Jackson
--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 217-30-1033	17. INFORMANT Mrs. Estella Taylor, 142 Mechanic St.	Address Frostburg, Md.
--	---	---	-------------------------------

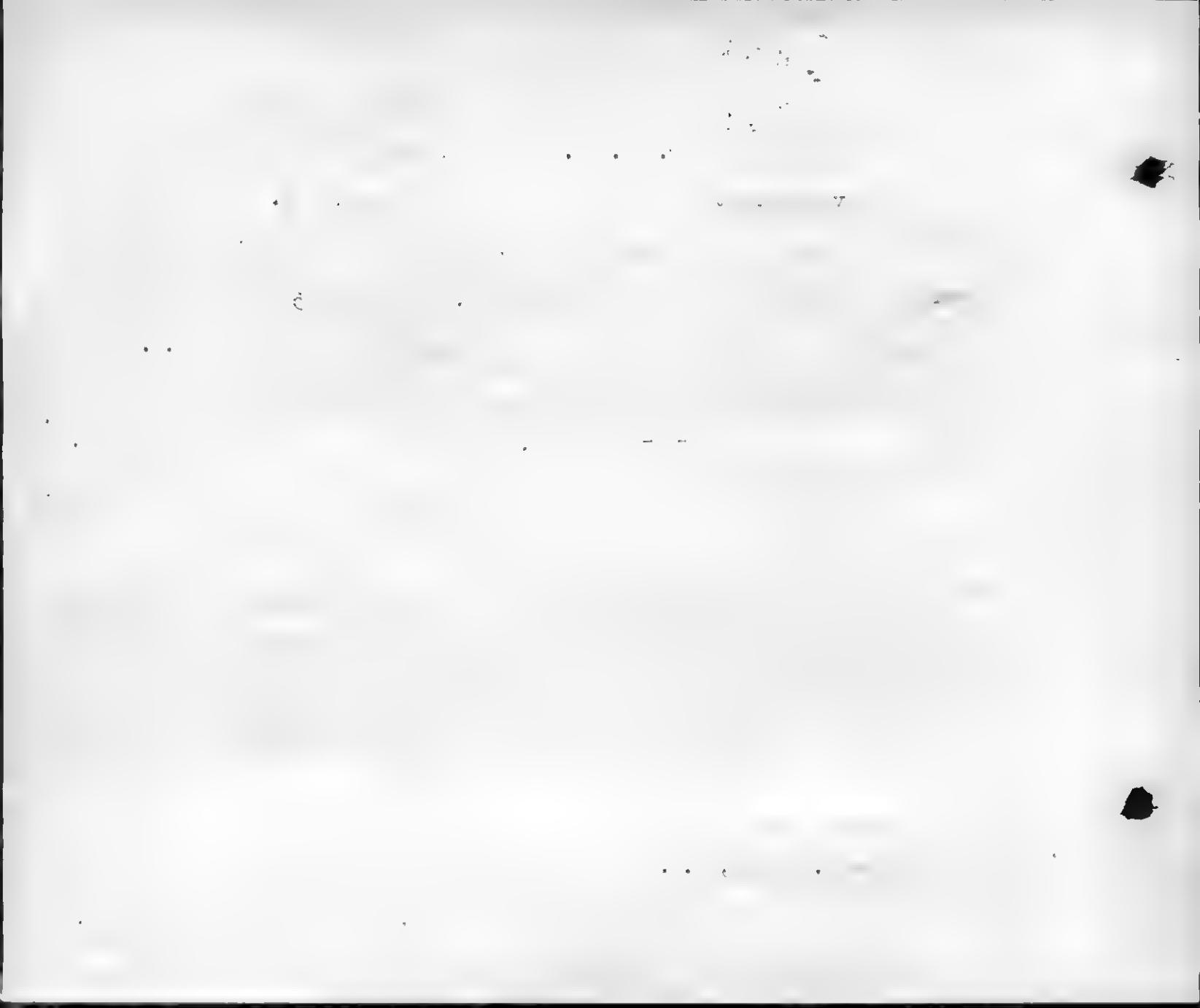
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	420 Coronary Thrombosis 950 General arteriosclerosis 290 Pernicious Anemia 301 Trace of depressive Reaction	INTERVAL BETWEEN ONSET AND DEATH Bradley ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 301 Trace of depressive Reaction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 25, 1957 to Apr. 27, 1958 , that I last saw the deceased alive on April 26, 1958 , and that death occurred at 6:45 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE James E. McLean, M.D.	ADDRESS (Street, city or town, state) 49 Prince St., Frostburg, Md.	DATE SIGNED 4-28-58
--	---	-------------------------------

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-30-1958	22c. NAME OF CEMETERY OR CREMATORIAL HOME Frostburg Memorial Pk.	22d. LOCATION (City, town, or county) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE O.H. Mattingly	ADDRESS Frostburg, Md.	24a. REC'D BY REGISTRAR DATE MAY 5 '58	24b. REGISTRAR'S SIGNATURE Albert Leach



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4:43

CERTIFICATE OF DEATH

Reg. Dist. No.

04036

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 13 DAYS	d. STREET ADDRESS CUMBERLAND		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		204 HAY STREET					
3. NAME OF DECEASED (Type or print)	First MARY	Middle M.	Last JOHNSON	4. DATE OF DEATH APRIL	Month 18	Day 1958	Year
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH JULY 23 1892	9. AGE (In years at birthday) 67 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) VALE SUMMIT, MD.		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HENRY CAIN			14. MOTHER'S MAIDEN NAME MARY BRADY				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>44-1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) <i>Cervical Occlusion involves Post operative large Multiple Ventral Hernia</i> INTERVAL BETWEEN ONSET AND DEATH							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state) DATE SIGNED							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 Apr 1958 to 18 Apr 1958 that I last saw the deceased alive on 18 Apr 1958 and that death occurred at 5:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>Tucker B. Whitworth</i>		PHYSICIAN'S NAME (Type) DR. FULLER WHITWORTH					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-21-58		22c. NAME OF CEMETERY OR CREMATORIUM SS. Peter & Paul		22d. LOCATION (City, town, or county) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				ADDRESS 24a. REC'D BY REGISTRAR DATE APR 24 '58			
				24b. REGISTRAR'S SIGNATURE W. L. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

LEADER V. S.

10-1959

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4044

CERTIFICATE OF DEATH

04037

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 24 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 229 Emily Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle A.	Last JONES	4. DATE OF DEATH April 8 1958	Month Day Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/31/85	9. AGE (In years lost birthday) 72 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Wales -Cardiff		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Robert Jones			14. MOTHER'S MAIDEN NAME Mary Ann Pryor			Address Pt.'s Chart -Sacred Heart Hospital		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No								
16. SOCIAL SECURITY NO. 17. INFORMANT Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of Lletum DUE TO 154X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO 								
INTERVAL BETWEEN ONSET AND DEATH 6 months								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 3 - 20 - 1958 , to 4 - 8 - 1958 , that I last saw the deceased alive on 4 - 8 - 1958 , and that death occurred at 12:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 57 Greene St, Cumberland Md DATE SIGNED 4-10-58								
ACTUAL SIGNATURE L Brings								
22. BURIAL, CREMATION, REMOVAL (Specify) Burial 4-11-1958								
22b. DATE THEREOF 4-11-1958		22c. NAME OF CEMETERY OR CREMATORIUM St. Patrick's Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.								
ADDRESS		24a. REC'D BY REGISTRAR APR 14 '58		24b. REGISTRAR'S SIGNATURE Alfred E. Scarpelli				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please retain carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

20 V. 2

APR 12 1964

20 V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4745

CERTIFICATE OF DEATH

Reg. Dist. No.

04038

1. PLACE OF DEATH o COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 21 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d STREET ADDRESS 11 Marion Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) LEMUEL		First LEMUEL	Middle SAMUEL	Lost KELSO	4. DATE OF DEATH April 2 1958	Month April	Day 2	Year 1958	
5. SEX Male		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH December 27, 1871	8. AGE (In years lost birthday) 87 yrs.	9. IF UNDER 1 YEAR Months 11	IF UNDER 24 HRS. Days Marion St.	Hours Cumberland, Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY General Farming		11. BIRTHPLACE (State or foreign country) Hampshire County, West Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Kelso		14. MOTHER'S MAIDEN NAME Minerva Spaid							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or date of service)		17. INFORMANT Mrs. Leona Webster		Address 11 Marion St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) arturoclerotic heart disease						INTERVAL BETWEEN ONSET AND DEATH 1 year			
DUE TO 4 d.o.c.		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) atherosclerosis (generalized)		DUE TO 2 years					
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 57 Greene St., Cumberland, Md.		20f. (City or town) Cumberland		(County) Calvert Co.	(State) Maryland
21. I certify that I attended the deceased from 7-4-1956 to 4-2-1958 , that I last saw the deceased alive on 4-1-1958 , and that death occurred at 11A M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 57 Greene St., Cumberland, Md.		DATE SIGNED 4-2-58	
ACTUAL SIGNATURE L. Brings									
PHYSICIAN'S NAME (Type) L. Brings		N.D. 57 Greene St., Cumberland, Maryland						4/2/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 5, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		24a. REC'D BY REGISTRAR APR 7 1958		24b. REGISTRAR'S SIGNATURE			
				DATE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WEGEVLE
HET HUUR

1000

may be retained by the hospital or attending physician; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #9-Film C288 - 4/29/58 - 18
CERTIFICATE OF DEATH

04039

Reg. Dist. No.

4046

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLERSLIE		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First MARGARET	Middle E.	Last LAFFERTY	4. DATE OF DEATH APRIL 16 1958	Month APRIL	Day 16	Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 15 1880	9. AGE (In years last birthday) 77 yrs	IF UNDER 1 YEAR Months 77	IF UNDER 24 HRS Days 77	Hours 15	Min 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) PENNA		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME HENRY OSTER				14. MOTHER'S MAIDEN NAME ELIZABETH BINGHAM				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO 215-07-3002		17. INFORMANT James O. Lafferty Ellerslie, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								
Acute Chelro-Vascular Accident 15 days INTERVAL BETWEEN ONSET AND DEATH								
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Apr 1 1958 to Apr 16 1958 that I last saw the deceased alive on Apr 16 1958 , and that death occurred at 12:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) John A. Topper M.D. Hyndman, Pa. DATE SIGNED 4/16/58								
ACTUAL SIGNATURE John A. Topper M.D. Hyndman, Pa. PHYSICIAN'S NAME (Type) JOHN A. TOPPER John A. Topper M.D. Hyndman, Pa.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 19, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Pleasant Ridge		22d. LOCATION (City, town, or county) Buffalo Mills, Pa. RD 1		
23. FUNERAL DIRECTOR'S SIGNATURE Alvap. Seeger, Hyndman, Pa.		ADDRESS Hyndman, Pa.		24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE W. E. Smith		

3. V. S.

21 1958

REVISE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained in a hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4047

CERTIFICATE OF DEATH

Reg. Dist. No.

04040

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 45 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.		d. STREET ADDRESS 508 Sheridan Place		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 508 Sheridan Place				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) George		First	Middle	Last	4. DATE OF DEATH April 19,	Month	Day	Year 19 58
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1897	9. AGE (In years last birthday) yrs. 61	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst Car Foreman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Allegany, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Maguire				14. MOTHER'S MAIDEN NAME Margaret Whalley				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 705-09-9698		17. INFORMANT Mary Kifer Maguire		Address 508 Sheridan lace		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 241X								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO saint (c) Pneumoblast Asthma DUE TO 8 yrs. (d) Myocarditis DUE TO 5 yrs.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 1957 to Apr. 20, 1958 , that I last saw the deceased alive on Apr. 12, 1958 , and that death occurred at 9:10 P.M. from the causes and on the date stated above		ADDRESS (Street, city or town, state) Cumberland, Md. 4/21/58.						
ACTUAL SIGNATURE Clay E. Durrett		DATE SIGNED 4/21/58.						
PHYSICIAN'S NAME (Type) Clay E. Durrett 236 Virginia Ave. Cumberland, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-23-58		22c. NAME OF CEMETERY OR CREMATORIUM At. Marys Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR APR 23 '58		24b. REGISTRAR'S SIGNATURE Scarpelli		

RECEIVED
BUREAU W. A.

APR 23 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4048 CERTIFICATE OF DEATH

Reg. Dist. No.

04041

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] CUMBERLAND		c. LENGTH OF STAY IN 1b 26 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
						c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] CUMBERLAND			
d. NAME OF HOSPITAL [If not in Hospital, give street address] OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES				d. STREET ADDRESS 105 FIFTH STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES WEBSTER		First MIDDLE MAHANEY		Last MAHANEY		4. DATE OF DEATH 4 15 1958		Month Day Year	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-16-1870		9. AGE (In years from birthday) 88 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brakeman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME NATHAN MAHANEY		14. MOTHER'S MAIDEN NAME SARAH SCHMIDT							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 705-07-9525		17. INFORMANT Mrs. Flora Mae Brown, Cumberland, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <i>Chronic Nephritis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO <i>Chronic Nephritis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>					
DUE TO (c)									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		<i>High blood pressure and tuberculosis</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>From falls</i>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>At home</i>		20f. (City or town) <i>Cumberland</i>		(County) (State) <i>Cumberland, Md.</i>	
21. I certify that I attended the deceased from <i>4/12/58</i> , 19, to <i>4/15/58</i> , 19, that I last saw the deceased alive on <i>4/15/58</i> , 19, and that death occurred at <i>10:12 AM</i> , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <i>Cumberland, Md.</i>	
ACTUAL SIGNATURE <i>Dr. R. J. Williams</i>								DATE SIGNED <i>4/16/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-18-58		22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 18 '58		24b. REGISTRAR'S SIGNATURE <i>Alt. Beach</i>			

BUREAU V. S

APP 1000

REGISTRE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4101

CERTIFICATE OF DEATH

04042

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE [Where deceased lived. If institution Residence before admission] a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11 mo., 25 days.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - near Cumberland	
3. NAME OF DECEASED (Type or print) Lincoln		First A.	Middle Last Martz
4. DATE OF DEATH April 20	Month Day 19 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Aug. 23, 1862
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) 95 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herman Martz		14. MOTHER'S MAIDEN NAME (Unknown) Ringler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Homer Martz, Rt 3, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 452 Chronic Myocarditis		?	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) 306 Cerebral arteriosclerosis		?	
DUE TO (c) Senile Deterioration		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 304 Senile psychosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 26, 1957 to April 20, 1958 that I last saw the deceased alive on April 19, 1958, and that death occurred at 2:15 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) James E. McLean, M.D. 49 Greene St. - DATE SIGNED ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) James E. McLean, M.D. 7/21/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 23/58	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Lebanon Cemetery		22d. LOCATION (City, town, or county) Glenco	
(State) Penna			
23. FUNERAL DIRECTOR'S SIGNATURE Timothy Konhaus		ADDRESS Meyersdale, Pa.	
		24a. REC'D BY REGISTRAR APR 23 '58	
		DATE	
		24b. REGISTRAR'S SIGNATURE Albrecht	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, in any event within 72 hours after death.

BUREAU X. S.

APR 23 1958

REGELIV EDE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4-49

Item # 5114285-15-79 et

CERTIFICATE OF DEATH

Reg. Dist. No.

04043

1. PLACE OF DEATH C COUNTY <i>Allendale Co.</i>		2. USUAL RESIDENCE (Where deceased lived) If institution, Residence before admission) a. STATE BARTON MARYLAND C. LENGTH OF STAY IN lb MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BARTON		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First ROBERT	Middle M. CORMICK	Last APRIL 20 1958	
4. DATE OF DEATH	Month APRIL	Day 20	Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/14, 1882	
9. AGE (In years lost birthday) yrs. 76	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME JOSEPH MCCORMICK	14. MOTHER'S MAIDEN NAME JANE?	Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
PTS. CHART.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>GANGRENE LEFT LEG - 30%</i>				1 day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO <i>EMBOLISM LEFT PAPILLARY APERTURE</i>				14 days
DUE TO <i>A TORN ULTRAVIOLET HEART VALVE</i>				17 days
(c) <i>Advanced gangrene</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>3/14</i> , 19 <i>58</i> , to <i>3/15</i> , 19 <i>58</i> that I last saw the deceased alive on <i>1/21</i> , 19 <i>58</i> , and that death occurred at <i>5 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED <i>3/15/58</i>
ACTUAL SIGNATURE <i>Allendale Co.</i>		M.D. <i>55 Broad St</i>		
PHYSICIAN'S NAME (Type) <i>JOHN L. MCNAUL</i>		<i>Angel Island, N.Y.</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>4/23/58</i>	22c. NAME OF CEMETERY OR Crematory <i>Scarsel Hall</i>	22d. LOCATION (City, town, or county) <i>Moscow</i>	(State) <i>N.Y.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. Koval-Westminster, MD</i>	ADDRESS <i>1761 1/2 Main 11D</i>	24a. REC'D BY REGISTRAR DATE <i>APR 24 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Altman</i>	

BUREAU V. S.

400-6-450

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4023

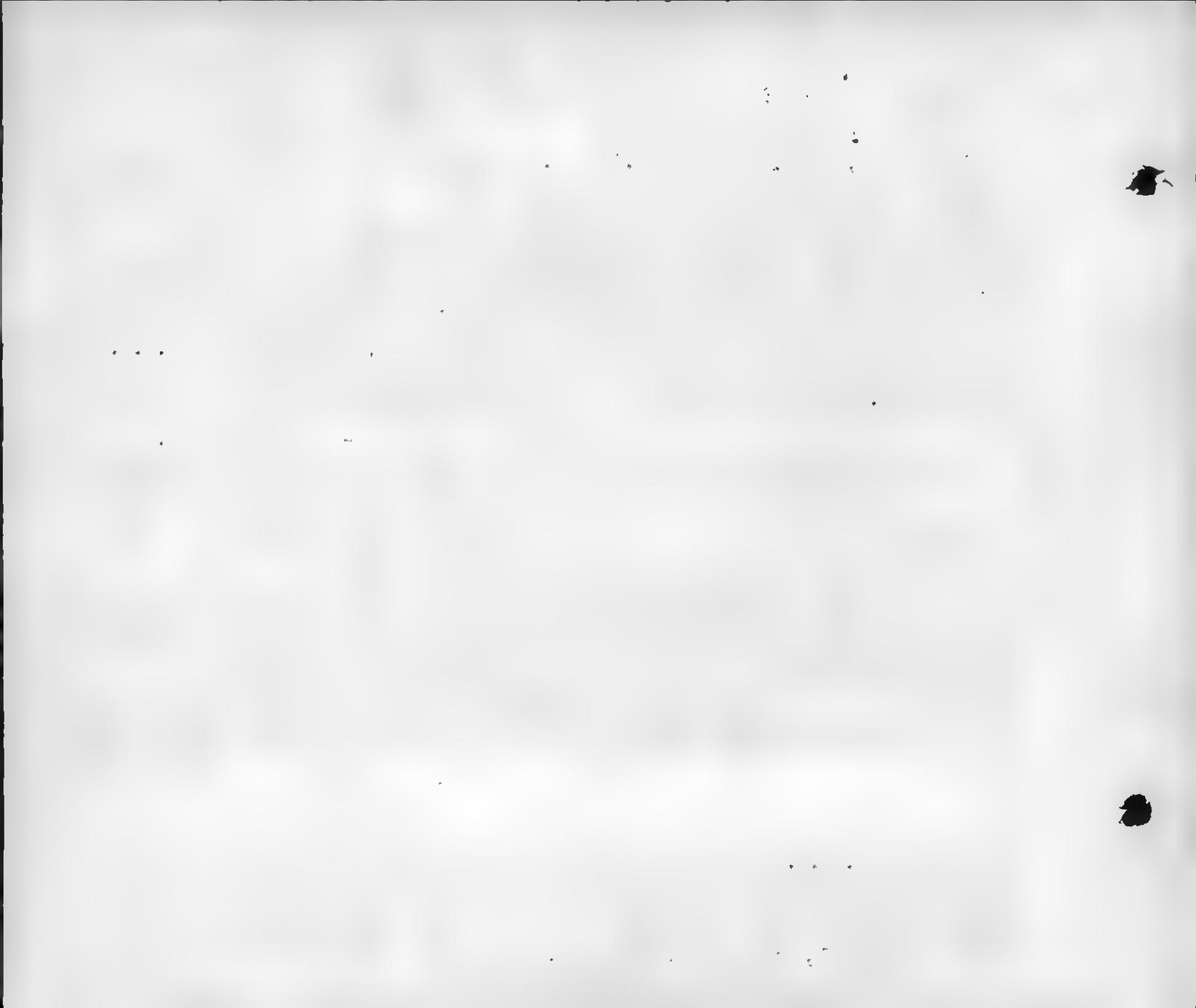
CERTIFICATE OF DEATH

Reg. Dist. No.

04011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN 1b 2 HRS. 10 MIN.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RAWLINGS	
3. NAME OF DECEASED (Type or print)		First BABY	Middle BOY MC CUSKER
4. DATE OF DEATH APRIL 26 1958		Month APRIL	Day 26 Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 26, 1958
9. AGE (In years lost birthday) yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OLIVER D. MC CUSKER		14. MOTHER'S MAIDEN NAME LORENA HAMPTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		<i>Breuer clarity</i>	
(b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 12:50 AM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Dallas B. Whitworth</i> ADDRESS (Street, city or town, state) <i>Cumberland MD</i> DATE SIGNED <i>28 Apr.</i>			
PHYSICIAN'S NAME (Type) DR. F.B. WHITWORTH		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	
22b. DATE THEREOF <i>4-27-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Memorial Hospital</i>	
23. FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital, Cumberland, Maryland.		24a. REC'D BY REGISTRAR DATE <i>MAY 1 '58</i>	
ADDRESS <i>Memorial Hospital, Cumberland, Maryland.</i>		24b. REGISTRAR'S SIGNATURE <i>R. L. Deasey</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4950

CERTIFICATE OF DEATH

Reg. Dist. No 04044

1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 9 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Dominick	Middle Arnold	Mc Greevy McGreevy	4. DATE OF DEATH April	Month 29	Day Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/13/94	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver				10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Thomas Mc Greevy				14. MOTHER'S MAIDEN NAME Nancy Arnold				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. War I		17. INFORMANT Pt's chart.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 DUE TO Pulmonary Hemorrhage INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) nonchogenic ONSET AND DEATH DUE TO aspirational 9 days (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 456 N. Centre St	(County) Cumberland, Md.	(State) MD
21. I certify that I attended the deceased from 4/20 , 19 58 , to 4/29 , 19 58 , that I last saw the deceased alive on 4/28 , 19 58 , and that death occurred at 4:00 AM , from the causes and on the date stated above.								
ACTUAL SIGNATURE Leo H. Ley Jr. ADDRESS (Street, city or town, state) 456 N. Centre St DATE SIGNED 4/29/58								
PHYSICIAN'S NAME (Type) LEO H. LEY JR. M.D. CUMBERLAND, MD.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 2, 1958	22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery				22d. LOCATION (City, town, or county) Cumberland, Md. (State) MD		
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				ADDRESS	24a. REC'D BY REGISTRAR 2/38	DATE MAY	24b. REGISTRAR'S SIGNATURE Scarpelli	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4102 CERTIFICATE OF DEATH

Reg. Dist. No. 41045

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaVale		c. LENGTH OF STAY IN 1b LaVale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaVale		d. STREET ADDRESS 719 LaVale Terrace		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 719 LaVale Terrace.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Howard Louis Mignot		First Howard	Middle Louis	Last Mignot	4. DATE OF DEATH April 15,	Month 1958	Day 19	Year 58
5. SEX Hale	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 12, 1899	9. AGE (In years lost birthday) 59 yr	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Yard Clerk		10b. KIND OF BUSINESS OR INDUSTRY Western Md. R. R.		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Charles L. Mignot				14. MOTHER'S MAIDEN NAME Annie Greider				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)		16. SOCIAL SECURITY NO 705-10-6364		17. INFORMANT Mrs. Howard Mignot, 719 LaVale Terr., LaVale, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		<i>Hypertensive Cardiovascular Disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>Since 12-12-56</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, Md.		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 12-12-56 , to 4-15-58 , that I last saw the deceased alive on 4-15-58 , and that death occurred at 7 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) William F. Williams, M.D., Cumberland, Md. DATE SIGNED 4-15-58								
ACTUAL SIGNATURE William F. Williams, M.D.								
PHYSICIAN'S NAME (Type) William F. Williams, M.D.		Cumberland, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 17, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Eckhart Cemetery		22d. LOCATION (City, town, or county) (State) Eckhart, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		ADDRESS Charles L. George, Cumberland, Md.						
24a. REC'D BY REGISTRAR DATE APR 17 '58		24b. REGISTRAR'S SIGNATURE Charles L. George						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

7 17 1958

DEPARTMENT OF
INTERNAL SECURITY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4051

CERTIFICATE OF DEATH

Reg. Dist. No.

04046

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY ALLEGANY		MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) o. STATE MARYLAND		b. COUNTY ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 1/2 HOURS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONACONING, MD.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 3 WEST MAIN STREET	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First BABY	Middle GIRL	4. DATE OF DEATH	Month APRIL	Day 17
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 17, 1953	9. AGE (In years lost birthday) 5 1/2 HRS. XX	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? CUMBERLAND, MD.
13. FATHER'S NAME EARL C. MILLER		14. MOTHER'S MAIDEN NAME KAFER, ANN ELIZABETH		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT		
			MEMORIAL HOSPITAL	INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line) For (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		Prematurity (21 wks)			
(c)					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4/17/58	20f. (City or town) CUMBERLAND	(County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from the causes and on the date stated above. ACTUAL SIGNATURE W.R. Hodges				ADDRESS (Street, City or town, State) Cumberlnd, Md.	
PHYSICIAN'S NAME (Type)				DATE SIGNED 4/18/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF April 18, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Memorial Hospital	22d. LOCATION (City, town, or county) Cumberland	(State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR PR 28 '58	24b. REGISTRAR'S SIGNATURE Hebeach	

BUREAU

ADP

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

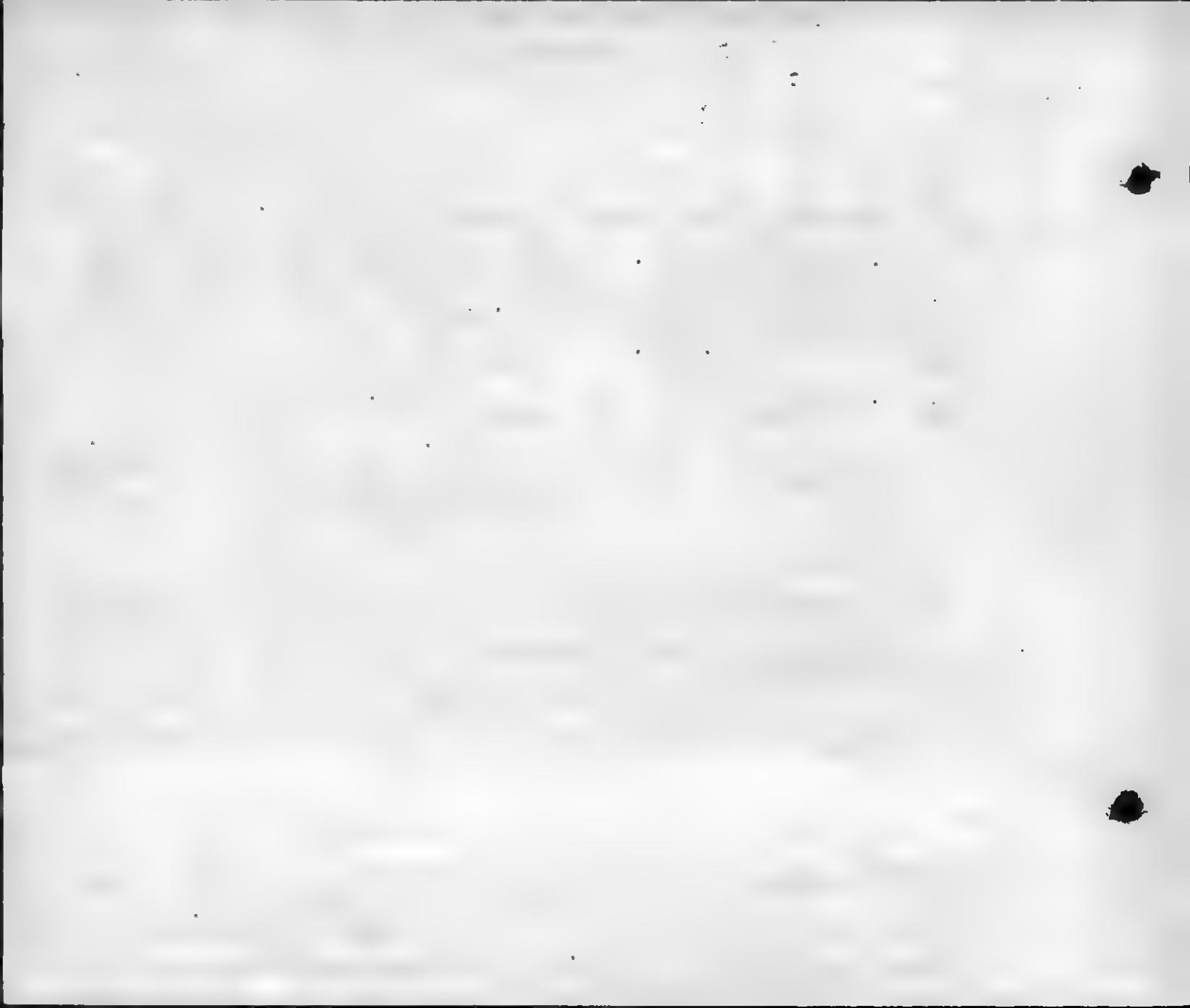
4052

CERTIFICATE OF DEATH

Reg. Dist. No.

04047

1. PLACE OF DEATH a. COUNTY		Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 704 Frederick Street		d. STREET ADDRESS 704 Frederick St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clement		First H.	Middle	Last MILLER	4. DATE OF DEATH April 28,
5. SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1893	9. AGE (in years (at birthday) 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY B. & O.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Henry C. Miller		14. MOTHER'S MAIDEN NAME Mary K. Siehl		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 705 09 8672		17. INFORMANT Emma E. Miller, Cumberland, Md. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
40.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO			
{ DUE TO (c)					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Last seen to 10-20-55</u> that I last saw the deceased alive on <u>10-20-1955</u> , and that death occurred at <u>Cumberland</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Mr. F. Williams</u> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <u>Cumberland, Md.</u> DATE SIGNED <u>4-28-58</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 1, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Hyndman Cemetery	
22d. LOCATION (City, town, or county) Hyndman, Pa.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE MAY 1 '58	
				24b. REGISTRAR'S SIGNATURE <u>Reed Smith</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4986

CERTIFICATE OF DEATH

Reg. Dist. No. 04648

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md.		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 330 E. Main Street		d. STREET ADDRESS 330 E. Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Eliza		First A.	Middle . Miller	Year 4	Month II	Day 1958	Year	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 21 1864	9. AGE (In years last birthday) 94 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		11. BIRTHPLACE (State or foreign country) Zihlman Md.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Jobe Stevens		14. MOTHER'S MAIDEN NAME Agnes Stephens		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. Address Mrs. Grace Mont, 330 E. Main St. Frostburg		17. INFORMANT Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 4-0-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Atherosclerotic Heart des. (c) DUE TO yeom.								INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy at work <input type="checkbox"/> at work <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frostburg	(County) Md.	(State) Md.	
21. I certify that I attended the deceased from April 11, 1958 , to April 11, 1958 , that I last saw the deceased alive on April 11, 1958 , and that death occurred at 8 P.M. , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>John C. Stevens</i>	ADDRESS (Street, city or town, state) 134 E Main						DATE SIGNED 4/13/58	
PHYSICIAN'S NAME (Type) John C. Stevens	Frostburg, Md.							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-14-1958	22c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Pk.	22d. LOCATION (City, town, or county) Frostburg	(State) Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Harter Funeral Home	ADDRESS Frostburg, Md.	24a. REC'D BY REGISTRAR APR 17 1958	24b. REGISTRAR'S SIGNATURE Alt. Leach					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU MAIL

• 17 1989

KODAK FILM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04049

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lenaconing			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS Watercliffe Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Jessie	Middle Waddell	Last Miller	4. DATE OF DEATH April 14 1958	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 20, 1874	9. AGE (In years lost birthday) 83 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Lenaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Waddell		14. MOTHER'S MAIDEN NAME Jessie Graham					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. William Ternent		Address Lenaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO <i>acute left heart failure, myocarditis</i>		"Daughter"		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)		DUE TO <i>chronic congestive heart fail.</i> <i>atrial fibr.</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>hypertension</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 19, 1958 , to April 14, 1958 , that I last saw the deceased alive on April 14, 1958 , and that death occurred at Lenaconing, Md. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>Leslie R. Miles, Jr., M.D.</i>							
PHYSICIAN'S NAME (Type) Leslie R. Miles, Jr., M.D.				Lenaconing, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/17/58		22c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lenaconing, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lenaconing, Md.		24a. REC'D BY REGISTRAR APR 18 1958		24b. REGISTRAR'S SIGNATURE <i>Debresch</i>	

BUREAU V. S

RECORDED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4053

CERTIFICATE OF DEATH

04050

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use as the burial-tranit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 52 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Baltimore Pike-Cumberland, Md		e. IS RESIDENCE ON FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ludovicus		First Miller	Middle Last
4. DATE OF DEATH April 6 1958	Month Day Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1861
9. AGE (In years last birthday) 96 yrs.		10. IF UNDER 1 YEAR Months 96	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY At home	
10c. BIRTHPLACE (State or foreign country) Bedford County Pa.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John P. Morse		14. MOTHER'S MAIDEN NAME Susanna Clingerman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None	17. INFORMANT Roy C. Miller Cumberland, Md
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDITIS, WITH CONGESTIVE FAILURE		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO ArTERIOSCLEROSIS, GENERALIZED		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JUNE 1957 to APRIL 1958 , that I last saw the deceased alive on 4.2.58 , and that death occurred at 1:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William V. Jensen		M.D. 441 N. CENTRE ST. 4.7.58	
PHYSICIAN'S NAME (Type) W. P. JAMES, M. D.		CUMBERLAND, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/58	22c. NAME OF CEMETERY OR CREMATORIUM Pleasant Grove
22d. LOCATION (City, town, or county) Cumberland Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE APR 9 '58	
		24b. REGISTRAR'S SIGNATURE Alv. Reisch	

BUNAU V. S.

APR 9 1966

KELLOGG

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04051

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-tombstone permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

4988				22d. LOCATION (City, town, or county) Frostburg, Md. (State)				
1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md. b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Klondike Frostburg		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Klondike				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		e. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mary Ada Miller		First	Middle	Last	4. DATE OF DEATH April 8 1958	Month	Doy	Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18-1902	9. AGE (In years last birthday) 55 yrs	10. UNDER 24 HRS Months 0	Days 0	Hours Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Carlsbad, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James Winter		14. MOTHER'S MAIDEN NAME Elizabeth Densmore						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO none		17. INFORMANT (nephew) Wm. Yates, Carlos, Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral hemorrhage (apoplexy)		INTERVAL BETWEEN ONSET AND DEATH about 3 hrs.		
		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b)				
		DUE TO (c)						
19. MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour a. m. p. m. 19		Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>		DATE SIGNED						
EXAMINER'S NAME (Type) H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> April 9-1958						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/11/58	22c. NAME OF CEMETERY OR CREMATORIUM Memorial Park		22d. LOCATION (City, town, or county) Frostburg, Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lenacening, Md.		24a. REC'D BY REGISTRAR DATE APR 14 '58		24b. REGISTRAR'S SIGNATURE <i>C. J. Stedeb</i>		

BEREAU V. S.

23 - 4 1968

BEREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4054

CERTIFICATE OF DEATH

04052

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First AGNES	Middle REGINA	Last MORELAND	4. DATE OF DEATH APRIL 6 1958	Month	Day	Year
--	--	-------------	---------------	---------------	----------------------------------	-------	-----	------

S. SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 19, 1887	9. AGE (In years lost birthday) 70 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min
------------------	--------------------------	---	------------------------------------	---	---------------------------	-------------------------	-------	-----

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE & Grocery Clerk	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	-----------------------------------	---	--

13. FATHER'S NAME JOHN THOMAS GRIFFIN	14. MOTHER'S MAIDEN NAME LAURA JOHNSON
--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	16. SOCIAL SECURITY NO. 214-32-3272B	17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND	Address
---	---	---	---------

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4443X</i> DUE TO <i>Thrombosis</i>		2 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Myocarditis & Decompensation</i> DUE TO <i>Hypertension</i> (c)		2 yrs 8 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <i>June</i> , 1957, to <i>Apr. 6</i> , 1958, that I last saw the deceased alive on <i>Apr. 5</i> , 1958, and that death occurred at <i>12:30 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)
---	--	---------------------------------------

ACTUAL SIGNATURE *Clay B. Durrett* M.D. 236 W. 1st Cumberland, Md. 4/6/58

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-8-58	22c. NAME OF CEMETERY OR CREMATORIUM St. Mary Cemetery	22d. LOCATION (City, town, or county) Cumberland, Md. (State)
---	-----------------------------	---	--

23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli	ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE APR 9 '58	24b. REGISTRAR'S SIGNATURE <i>D. L. Smith</i>
--	----------------------------	---	--

BUREAU V. A.

APR 9 1959

FILE - 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4:55

CERTIFICATE OF DEATH

04053

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b 7/31/57		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 603 Leiper Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle W.	Last Morgan
4. DATE OF DEATH	Month April	Day 26,	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9/18/1870
9. AGE (In years last birthday) 87	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hrs 0
13. FATHER'S NAME Samuel Morgan	14. MOTHER'S MAIDEN NAME Mary Robertson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 17 Informant P. O. Box 599 Allegany County Infirmary Records	17. ADDRESS Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (d) PART III. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 7/31/57 , 19, to 4/26/58 , 19, that I last saw the deceased alive on 4/26/58 , 19, and that death occurred at 3:40 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE James E. McLean ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED 4/28/58 PHYSICIAN'S NAME (Type) Dr. James E. McLean CUMBERLAND, MARYLAND 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Apr. 28, 1958 22c. NAME OF CEMETERY OR CREMATORIUM Prosperity Meth Cemetery 22d. LOCATION (City, town, or county) Beans Cove, Alleg. Co. (State) 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John J. Hafer, Cumberland, Maryland 24a. REC'D BY REGISTRAR DATE MAY 1 '58 24b. REGISTRAR'S SIGNATURE Albert Hafer MD.			

37

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in my [redacted] within 72 hours after death.

V.S. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4056 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04054

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PA.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MEYERSDALE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS Lincoln Ave	
e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ETHEL	Middle C.	Last MURRAY
4. DATE OF DEATH	Month APRIL	Day 14	Year 1958
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JULY 25 1895
9. AGE (In years last birthday) 62 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) MEYERSDALE, PA.
13. CITIZEN OF WHAT COUNTRY? U.S.A.	14. MOTHER'S MAIDEN NAME SHULTZ, AMANDA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No	16. SOCIAL SECURITY NO. No.	17. INFORMANT	Address MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION INTERVAL BETWEEN ONSET AND DEATH SUDDEN			
19. DUE TO			
Conditions, if any, which gave rise to immediate cause (b) CORONARY OCCLUSION ABOUT 1 YR.			
20. DUE TO			
Conditions, if any, which gave rise to underlying cause (c) CORONARY SCLEROSIS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Hour o. m. p. m.	19	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE DR. H. V. DEMING M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED APRIL 15, 1958
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 18 1958	22c. NAME OF CEMETERY OR CREMATORIUM Union Cemetery	23. LOCATION (City, town, or county) Meyersdale Pa.
(State)			
23. FUNERAL DIRECTOR'S SIGNATURE William Rose Price	ADDRESS Mayfield Pa.	24a. REC'D BY REGISTRAR APR 22 '58	24b. REGISTRAR'S SIGNATURE Abel Leach
(State)			

RECEIVED
BUREAU Y.

APR - 1944

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04655

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Rural

1. PLACE OF DEATH a. COUNTY		4103		2. USUAL RESIDENCE (Where deceased lived if institutional Residence before admission)	
Allegany		MARYLAND		b. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Rt. # 1		c. LENGTH OF STAY IN lb 5 yrs		b. COUNTY Allegany	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bowmans Addition		d. STREET ADDRESS Bowmans Addition		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Glen Foster Nelson		4. DATE OF DEATH April 18 1958		Month Day Year	
5. SEX Male white WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6. COLOR OR RACE March 18-1915		9. AGE (In years last birthday) 43 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Petersburg, W.Va.	
13. FATHER'S NAME James E. Nelson		14. MOTHER'S MAIDEN NAME Provie Turner		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes W.W.2		16. SOCIAL SECURITY NO 214-07-2223		17. INFORMANT Mrs. Rose Mongold 159 Polk St., Cumberland, Md. Reside	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO (c) _____		Cerebral hemorrhage (apoplexy)		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) H. V. Deming M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> April 20-1958			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/58		22c. NAME OF CEMETERY OR CREMATORIAL Davis Memorial Burial Pk. Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR	
				24b. REGISTRAR'S SIGNATURE APR 24 58 Alt. J. eden	

BUKEAU V. S

APR 9 1958



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4089

CERTIFICATE OF DEATH

04056

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by this funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ISABELLE	Middle B.	Last NOEL	4. DATE OF DEATH	Month 4/17/1958	Day	Year 19
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/5/1883	9. AGE (In years last birthday) 75 yrs	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Barton, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Reid				14. MOTHER'S MAIDEN NAME Agnes Garner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. CARL EWALD, Mt. SAVAGE, MD. (SISTER)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anterior-lateral Infant Cardiac Murmur DUE TO (c) 10 days INTERVAL BETWEEN ONSET AND DEATH 3 hrs -							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1958 , to April 17, 1958 , that I last saw the deceased alive on April 17, 1958 , and that death occurred at 11:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE John B. Davis, M.D. ADDRESS (Street, city or town, state) 2 B Broadway DATE SIGNED 4/21/58 PHYSICIAN'S NAME (Type) John B. Davis, M.D. Frostburg, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/20/1958		22c. NAME OF CEMETERY OR CREMATORIUM Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN, LONACONING, MD.				ADDRESS		24a. REC'D BY REGISTRAR DATE APR 21 '58	24b. REGISTRAR'S SIGNATURE DeLoach

BUREAU Y. S.

APR 21 19

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4057 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Reg. Dist. No. 04057
TO MEDICAL: This certificate should be examined within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the State Board of Health.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4057 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
		Reg. Dist. No. 04057									
I. PLACE OF DEATH a. COUNTY		Allegany			MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission)		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cumberland			c. LENGTH OF STAY IN lb 35yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cumberland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		437 Waverly Terrace			d. STREET ADDRESS 437 Waverly Terrace		e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Nina		Middle Pearl		Last Parsons		4. DATE OF DEATH Oct 1-1896		Month April	
5. SEX		6. COLOR OR RACE female white		7. MARRIED WIDOWED <input type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Oct 1-1896		9. AGE (In years last birthday) 61 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Crabottom, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Amlia Winer		14. MOTHER'S MAIDEN NAME Susan Palmer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. no		17. INFORMANT None		(husband) Emil Parsons, Cumberland, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH: Gradual									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial failure									
422.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		DUE TO (b) Chronic myocarditis DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		about 7 yrs									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 11-1958									
EXAMINER'S NAME (Type) H. V. Deming M.D.		22a. BURIAL, CREMATION REMOVAL (Specify) Burial									
22b. DATE THEREOF 4-14-58		22c. NAME OF CEMETERY OR CREMATORIUM Sunset Memorial Park		23d. LOCATION (City, town, or county) Cumberland, Md.		24a. RECEIVED BY REGISTRAR APR 14 1958		24b. REGISTRAR'S SIGNATURE <i>John J. Scarpelli</i>			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli Cumberland, Md.		ADDRESS <i>James F. Scarpelli</i>									
VS. A15ME SM 2 57											

BRUNSWICK V. S.

1955

BRUNSWICK V. S.

FOR STATE
HEALTH DERT.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 4^58 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 04058
 Reg. Dist No.
 This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PHM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4^58 MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
Reg. Dist No. 04058													
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Allegany									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN lb 22 yrs									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 420 Independence St.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland									
f. STREET ADDRESS 420 Independence St.				f. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Augusta Nues		First	Middle	4. DATE OF DEATH Month April Day 9 Year 1958									
5. SEX Female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3- 1893		9. AGE (in years from birthday) 64 yr.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Hartford, Conn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Julius Hallier													
14. MOTHER'S MAIDEN NAME Alice Nues													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT (daughter) Alice Wertz, Cumberland, Md.		Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH sudden several years.													
400.1 DUE TO (b) Arteriosclerosis with hypertension													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 9-1958							
EXAMINER'S NAME (Type) H. V. Deming M.D.		22b. DATE THEREOF 4/12/58		22c. NAME OF CEMETERY OR CREMATORIAL SUNSET MEMORIAL PARK		22d. LOCATION (City, town, or county) CUMBERLAND, MARYLAND		(State)					
22e. BURIAL CREMATION, REMOVAL (Specify) Burial		ADDRESS		24a. REC'D BY REGISTRAR APR 14 '58		24b. REGISTRAR'S SIGNATURE							
VS. AT 15 ME BM 2/57													

GOULDING & S.
102 2nd Street
GLENDALE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4059 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04059

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PH2. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE M d. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN TB 4 months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. at-Memorial Hospital	d. STREET ADDRESS 110 N.Ceder St.	e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mitchell	First T.	Middle Payne	4. DATE OF DEATH April 28 1958
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 16 1957
9. AGE (In years last birthday) 0 yrs	10. IF UNDER 1 YEAR Months 4 Days 0 Hours 0 Min 0	11. IF UNDER 24 HRS Months 4 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Cumberland, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Riley Payne	14. MOTHER'S MAIDEN NAME Margaret C. Priddey	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. none	17. INFORMANT (mother) Margaret C. Payne, Cumberland, Md.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation		INTERVAL BETWEEN ONSET AND DEATH sudden	
9210 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		?	
(b) Pulmonary edema and			
DUE TO Laryngospasum (c)		sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) stomach contents. Presume baby rolled over on abdomen, then aspiration of	
20c. TIME OF INJURY Month, Day, Year Hour 12 p.m. 4-28-1958		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) In a home
about		20f. (City or town) Cumberland, Allegany, Md.	(County) Allegany (State) Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 28-1958
22a. BURIAL, CREMATION, ETC. REMOVAL (Specify) Burial	22b. DATE THEREOF 4-30-58	22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park	22d. LOCATION (City, town, or county) Cumberland, Md. (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli	ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR 2 '58	24b. REGISTRAR'S SIGNATURE <i>Alfred J. Deuch</i>
VS A15ME BM 2-57			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4-60

CERTIFICATE OF DEATH

04060

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 29		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KITZMILLER		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First NELLIE	Middle PEARL	Last PERANDO	4. DATE OF DEATH APRIL 21	Month APRIL	Day 21	Year 1958
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 21	9. AGE (In years (last birthday) 62 yrs.)	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. OF AMERICA		
13. FATHER'S NAME GEORGE LOUGHRY				14. MOTHER'S MAIDEN NAME IDA MAY WRIGHT				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 253.0		<i>probable coronary</i>						
DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)						
DUE TO								
(c) <i>secondary to hyperthyroid - post operatus</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) CUMBERLAND		(State) MD.
21. I certify that I attended the deceased from Mar 23, 1958 , to April 21, 1958 , that I last saw the deceased alive on April 21, 1958 , and that death occurred at 5:15 PM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 22 Washington St.		DATE SIGNED
ACTUAL SIGNATURE <i>David H Miller</i>								
PHYSICIAN'S NAME (Type) DR. DAVID MILLER						<i>Cumberland Md.</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 4/24/58		22b. DATE THEREOF 4/24/58		22c. NAME OF CEMETERY OR CREMATORIUM Terra Alta Cemetery		22d. LOCATION (City, town, or county) Terra Alta, W. Va.		(State) W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Al Legerton - Cumberland Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 28 '58		24b. REGISTRAR'S SIGNATURE <i>John E. Martin</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

APR 6 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4061

CERTIFICATE OF DEATH

Reg. Dist. No.

04061

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE W. Va.		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wiley Ford, W. Va.		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Granville Roscoe Poland		First	Middle	Last	4. DATE OF DEATH 4/14	Month	Day	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4/2/88	9. AGE (In years lost birthday) 70 50 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fireman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Hampshire W. Va. - County		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Gerald Poland				14. MOTHER'S MAIDEN NAME Harriett Lewis				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Name, no. or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Pt's chart		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Brachial artery								
INTERVAL BETWEEN ONSET AND DEATH 12 hours								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Crush w/ coal tongs with coronary since 5 years						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 4 - 13 1958		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4 - 5 1958		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 4 - 5 1958 to 4 - 14 1958 , that I last saw the deceased alive on 4 - 13 1958 , and that death occurred at 12:30 A.M. from the causes and on the date stated above								
ACTUAL SIGNATURE J. Johnson Jr.		ADDRESS (Street, city or town, state) 16 Queen St Cumberland MD 21801						
PHYSICIAN'S NAME (Type) James F. Scarpelli		DATE SIGNED 4/15/58						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-16-58		22c. NAME OF CEMETERY OR CREMATORIUM Baptist Cemetery		22d. LOCATION (City, town, or county) Three Churches, W. Va.		
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS 24a. REC'D BY REGISTRAR DATE APR 17 '58						
		24b. REGISTRAR'S SIGNATURE A. Scarpelli						

BUREAU X-2

8 17 1959

REGIME

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4790

Item # File # 1228 5-12-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

04062

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md.		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb 3 wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Zihlman R. D. No 2, Frostburg		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Benjamin		First Franklin	Middle Porter	4. DATE OF DEATH 4 30 1958	Month Month	Day Days	Year Hours Min
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 9-10-1878	10. AGE (In years lost birthday) 79 ^{rs}	11. IF UNDER 1 YEAR Months	12. IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Zihlman		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Porter		14. MOTHER'S MAIDEN NAME Emma Burton					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 213-09-6471		17. INFORMANT R. D. No. 2, Box 129 Frostburg, Md. Mrs. Raymond Anderson, Grand Daughter		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 081.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Atherosclerotic heart disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March, 1958</u> , to <u>April, 1958</u> , that I last saw the deceased alive on <u>April 29, 1958</u> , and that death occurred on <u>29 M</u> , from the causes and on the date stated above ACTUAL SIGNATURE <u>John G. Devees</u> M.D. ADDRESS (Street, city or town, state) <u>134 E Main St. 1958</u> DATE SIGNED <u>5/1/58</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-2-1958		22c. NAME OF CEMETERY OR CREMATORIAL Porter Cemetery		22d. LOCATION (City, town, or county) Elkhart	
23. FUNERAL DIRECTOR'S SIGNATURE P. H. Mattingly		ADDRESS Hafer Funeral Home Frostburg, Md.		24a. REC'D BY REGISTRAR DATE MAY 5 '58		24b. REGISTRAR'S SIGNATURE W. L. esch	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4-62

CERTIFICATE OF DEATH

Reg. Dist. No.

04063

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY MINERAL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY, W.VA.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS RT. #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) FLOYD		First D.	Middle D.	Last POWELL	4. DATE OF DEATH APRIL 25 1958	Month APRIL	Day 25	Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7-26-1889	9. AGE (In years (as of birthday) 80 yrs.)	IF UNDER 1 YEAR IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLLER ROOM		10b. KIND OF BUSINESS OR INDUSTRY ALLEGANY BALISTICS		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WALTER POWELL		14. MOTHER'S MAIDEN NAME MARY ALENDER						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-7216		17. INFORMANT Mrs. Mary E. Powell		Address Rt. 1 Ridgeley, W. Va.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH 1 week		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral vascular accident						
420.0 DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Arteriosclerotic Heart Disease				1 year		
DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 62 Greene St.		20f. (City or town) (County) Cumberland, Md. (State)		
21. I certify that I attended the deceased from 4-6 1958 to 4-25 1958 , that I last saw the deceased alive on 4-25 1958 , and that death occurred at 1:40 PM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Neals Run, W. Va. DATE SIGNED 4-26-58		
ACTUAL SIGNATURE <i>Reya h. Ballin</i>		M.D.						
PHYSICIAN'S NAME (Type) DR. R. BALLIN								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-28-1958		22c. NAME OF CEMETERY OR CREMATORIUM Genevan Cemetery		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR APR 30 '58		24b. REGISTRAR'S SIGNATURE <i>John J. Ballin</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 30 1960

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4-63

Item 1 P. 1227 4-14-58 at

CERTIFICATE OF DEATH

Reg. Dist. No.

04064

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		b. COUNTY HAMPSHIRE	
c. LENGTH OF STAY IN 1b 11 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROMNEY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 456 GRAVEL LANE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First PEARL	Middle H.	Last PUE
4. DATE OF DEATH	Month APRIL	Day 3	Year 1958
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 11, 1872
9. AGE (In years last birthday) 75 1/2 yrs.		10. IF UNDER 1 YEAR Months 75	11. IF UNDER 24 HRS Days 16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
10c. BIRTHPLACE (State or foreign country) THREE CHURCHES, W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES THOMPSON		14. MOTHER'S MAIDEN NAME ELIZABETH PARKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>Aterio sclerotic cardio vascular disease</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 24, 1958 , to 4-2-1958 , that I last saw the deceased alive on 4-3-1958 , and that death occurred at 11:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Romney DATE SIGNED 4-4-58			
ACTUAL SIGNATURE W.F. Williams, M.D.			
PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 6	
22c. NAME OF CEMETERY OR CREMATORIAL Indian Mound		22d. LOCATION (City, town, or county) Romney (State) W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Keith Shoffner		ADDRESS Romney W Va.	
24a. REC'D BY REGISTRAR APR 9 '58		24b. REGISTRAR'S SIGNATURE DeLoach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DR 3 1959

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4-64

CERTIFICATE OF DEATH

04065

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>allegany</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>allegany</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>		c. LENGTH OF STAY IN 1b <i>First</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>		d. STREET ADDRESS <i>Willowbrook Rd.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Willowbrook Rd.</i>				d. STREET ADDRESS <i>Willowbrook Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>John</i>	Middle <i>Calvin</i>	Last <i>Reager</i>	4. DATE OF DEATH <i>Apr 2 1958</i>	Month <i>Apr</i>	Day <i>2</i>	Year <i>1958</i>	
S SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Sept 12, 1879</i>	9. AGE (In years, months, days, lost birthday) <i>78 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	IF UNDER 24 HRS Hours <i>0</i>	IF UNDER 24 HRS Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>B&O Railroad</i>		11. BIRTHPLACE (State or foreign country) <i>Warrenton Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S</i>			
13. FATHER'S NAME <i>Harry Reager</i>		14. MOTHER'S MAIDEN NAME <i>Mary Louise Payne</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>70</i>		17. INFORMANT <i>Jona Randall - Elm St - Cumberland</i>		Address <i>162 Elmwood</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i>		DUE TO <i>Arterio Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>162 hours</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Arteriosclerotic Cardio-Vascular Disease</i>		(c)		2 years					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Cumberland</i>		(County) <i>Maryland</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>20 January 1958</i> to <i>2 April 1958</i> , that I last saw the deceased alive on <i>1 April 1958</i> , and that death occurred at <i>5 P.M.</i> from the causes and on the date stated above		ADDRESS (Street, city or town, state) <i>M.D. 122 So. Centre St. Cumberland Maryland</i>						DATE SIGNED <i>3 April 1958</i>	
ACTUAL <i>James G. Stegmaier</i>		M.D. 122 So. Centre St. Cumberland Maryland							
PHYSICIAN'S NAME (Type) <i>James G. Stegmaier</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>4/4/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>		22d. LOCATION (City, town, or county) <i>Washington D.C.</i>		(State) <i>D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Hafer</i>		ADDRESS <i>Cumberland Md</i>						24a. REC'D BY REGISTRAR DATE <i>APR 7 '58</i>	
								24b. REGISTRAR'S SIGNATURE <i>John J. Hafer</i>	

REFUGEE
BUREAU

APR 7 1978

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4-65

CERTIFICATE OF DEATH

Reg. Dist. No.

04066

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be retained for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 13 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 801 MEMORIAL AVE						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First FRANCES	Middle PEARL	Last REITER	4. DATE OF DEATH APRIL 26 1958	Month APRIL	Day 26	Year 1958				
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 9, 1891	9. AGE (In years at birthday) 67 yrs	10. IF UNDER 1 YEAR Months 8	11. IF UNDER 24 HRS. Days 8	12. IF UNDER 24 HRS. Hours 8					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY School Teacher		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? Logsbury U.S.A.						
13. FATHER'S NAME NATHANIEL REPOGLE		14. MOTHER'S MAIDEN NAME ALICE MARKEY		Address CUMBERLAND, MD.								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO 215-36-8588		17. INFORMANT MEMORIAL HOSPITAL		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Gastric ulcer in left breast		INTERVAL BETWEEN ONSET AND DEATH 56				
{ b) c)		DUE TO Gastric ulcer in abdomen		DUE TO vulva.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Lumbar myelitis		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) CUMBERLAND, MD.		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20g. ADDRESS (Street, city or town, state) 4126		21. I certify that I attended the deceased from 12-12-1957 to 4-26-1958 that I last saw the deceased alive on 4-26-1958 , and that death occurred at 4:50 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Dr. F. Williams M.D.		DATE SIGNED 4-28-58						
PHYSICIAN'S NAME (Type)		DR. WILLIAM F. WILLIAMS		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Apr. 29, 1958		22b. DATE THEREOF Sunset Mem. Park		22c. NAME OF CEMETERY OR CREMATORIAL CUMBERLAND, MD.		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS John J. Hooper, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE MAY 1 '58		24b. REGISTRAR'S SIGNATURE Albert						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4066

CERTIFICATE OF DEATH

Reg. Dist. No.

04667

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		b. COUNTY Allegany	
c. LENGTH OF STAY IN lb Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 54 Oak Street		d. STREET ADDRESS 54 Oak Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Carl	Middle George	Last Reuschel
4. DATE OF DEATH	Month April	Day 8	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1901
9. AGE (In years last birthday) yrs 56	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carman	14. KIND OF BUSINESS OR INDUSTRY Railroad	15. BIRTHPLACE (State or foreign country) Cumberland, Md.	16. CITIZEN OF WHAT COUNTRY? USA
17. FATHER'S NAME George Reuschel	18. MOTHER'S MAIDEN NAME Louise Moot	Address	
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) no	20. SOCIAL SECURITY NO. 705-12-0870	21. INFORMANT Mrs. Barbara Murphy, Cumberland, Md.	22. INTERVAL BETWEEN ONSET AND DEATH Minutes
23. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Coronary Artery Disease (c) DUE TO Coronary Artery Disease		24. MEDICAL CERTIFICATION	
25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		26. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		28b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
29c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. — 19 —		30d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
30e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		31f. (City or town) (County) (State)	
32. I certify that I attended the deceased from 4/10/58 , 19, to 4/4/58 , 19, that I last saw the deceased alive on 4/3/58 , 19, and that death occurred at 4 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) B. J. Williams, M.D. 122 S. Centre St.		33. DATE SIGNED April 8, 1958	
34. ACTUAL SIGNATURE B. J. Williams, M.D.		35. PHYSICIAN'S NAME (Type) Richard J. Williams M.D.	
36. BURIAL, CREMATION, REMOVAL (Specify) Burial		37. DATE THEREOF Apr. 11, 1958	
38. NAME OF CEMETERY OR CREMATORIUM St. Luke's Cemetery		39. LOCATION (City, town, or county) Cumberland, Md.	
40. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		41. ADDRESS VS A15 (4) 15M 10/57	
42. REC'D BY REGISTRAR APR 14 '58		43. REGISTRAR'S SIGNATURE Carl Reuschel	

וְיַעֲשֵׂה יְהוָה

APR 14 1962

בְּרִית מֹשֶׁה

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4091

CERTIFICATE OF DEATH

Reg. Dist. No.

04068

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
3. NAME OF DECEASED (Type or print) Lillian Folk Richardson		d. STREET ADDRESS 163 Center Street	
4. DATE OF DEATH April 25th, 1958		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 18th, 1887	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years lost birthday) 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Charles W. Folk		14. MOTHER'S MAIDEN NAME Elizabeth Eisel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 213-09-6498B	
17. INFORMANT Earl Richardson, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c) DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Acute Peritonitis Incarcerated femoral hernia (Rt) Perforation small bowel (ileum) INTERVAL BETWEEN ONSET AND DEATH 3-4 days 2 1/2 wks 3-4 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) none.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 1 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-10, 1958 , to 4-25, 1958 , that I last saw the deceased alive on 4-25, 1958 , and that death occurred at 4:50 P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE H.C. Dietrich		ADDRESS (Street, city or town, state) 39 W. Main St., Frostburg, Md.	
DATE SIGNED 4/25/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-27-58	
22c. NAME OF CEMETERY OR CREMATORIUM Frostburg Memorial Park		22d. LOCATION (City, town, or county) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR APR 28 '58	
ADDRESS Joseph R. Durst, Frostburg, Md.		24b. REGISTRAR'S SIGNATURE G. L. Durst	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 8 1958

DEGELVÉ

may be retained by the hospital or attending physician and completely filled in by him.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by him, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item #9 - F

CERTIFICATE OF DEATH

04069

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN b 5 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
f. STREET ADDRESS 320 ARCH STREET		g. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First EMMA	Middle VICTORIA	Last RICKENBERG
4. DATE OF DEATH	Month 'APRIL	Day 3	Year 58
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 27 1883
9. AGE (In years last birthday) 70 1/4	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. KIND OF BUSINESS OR INDUSTRY WEST VIRGINIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME RICHARD STOTT	14. MOTHER'S MAIDEN NAME ANNA PETRY	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio Sclerotic Parkis was.</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>disease</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>since 1948</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4-3-1958	20f. (City or town) Martinsburg	(County) W. Va.
21. I certify that I attended the deceased from 8-31-1957 , to 4-3-1958 , that I last saw the deceased alive on 1-2-1958 , and that death occurred at 3:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. J. Williams</i>	ADDRESS (Street, city or town, state) <i>Memorial Hosp. Cumberland, Md.</i>		DATE SIGNED <i>4-7-58</i>
PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/5/58	22c. NAME OF CEMETERY OR CREMATORIAL Green Hill Cem.	22d. LOCATION (City, town or county) Martinsburg W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Hafer</i>	ADDRESS <i>Cumberland Md</i>	24a. REC'D BY REGISTRAR APR 7 '58	24b. REGISTRAR'S SIGNATURE <i>Webb</i>

STAN V. 2

1958

VED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4-68

CERTIFICATE OF DEATH

Reg. Dist. No.

04070

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY HAMPSHIRE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 16 32 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT. #50, ROMNEY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS MEMORIAL AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First NOAH	Middle MILES	Last RIGGLEMAN	4. DATE OF DEATH APRIL 23	Month Year 1958	Day	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 8-19-1887	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINER		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) KEYSER, W. VA.		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME NOAH RIGGLEMAN		14. MOTHER'S MAIDEN NAME ANGELINE ROHRBAUGH					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. 236-01-8940		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		aerobic Bone marrow Rheumatoid arthritis				INTERVAL BETWEEN ONSET AND DEATH 6 months 10 years	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour p. m.	Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 1225 Castro St.	(County)	(State)
21. I certify that I attended the deceased from 18 pm., 1954, to 23 pm., 1958, that I last saw the deceased alive on 22 pm., 1958, and that death occurred at 4:45 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 1225 Castro St. DATE SIGNED 23 pm. 58							
ACTUAL SIGNATURE W. Alfred Van Ormer		PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/27/58	22c. NAME OF CEMETERY OR CREMATORIAL Indian Mound Cemetery	22d. LOCATION (City, town, or county) Romney	(State) W. Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox	ADDRESS Cumberland, Maryland	24a. REC'D BY REGISTRAR APR 25 '58	24b. REGISTRAR'S SIGNATURE R. Silcox				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4. After this certificate has been signed by the attending physician and completely filled in by the general director, page 1 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or incineration.

DUKEAU V. S.

APR 5 1973



1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

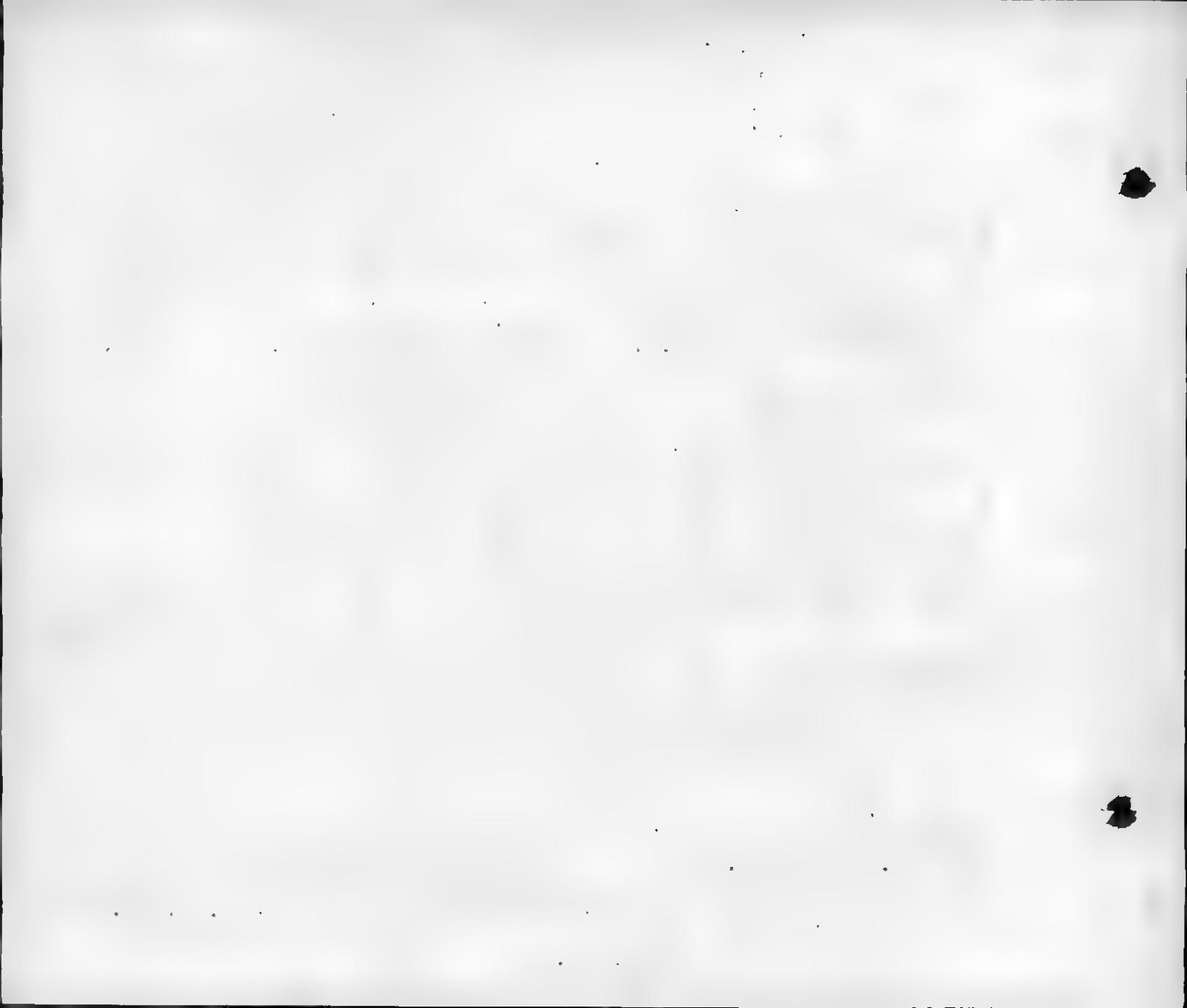
Reg. Dist. No.

04071

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a Burial (Death) permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, or in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		4. DATE 4-69		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 mo.		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 174 Baltimore St.		d. STREET ADDRESS 174 Baltimore St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Otha		First Otha	Middle Rollin	Last Roderick	4. DATE OF DEATH April 30 1958
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 20-1906	9. AGE (In years to nearest birthday) 52 yrs	IF UNDER 1 YEAR Months Days Hours Min. 0 0 0 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer for the U.S.G.		10b. BIRTHPLACE (State or foreign country) Hartmansville, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ephrim Roderick		14. MOTHER'S MAIDEN NAME Tolia Fout		Address Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 235-18-1178		17. INFORMANT (brother) Lawrence Roderick, Cumberland,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH Sudden	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		Coronary sclerosis		?	
(b)		Arteriosclerosis with hypertension		About 4 years.	
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED May 1-1958	
EXAMINER'S NAME (Type) H. V. Deming M.D.	22c. NAME OF CEMETERY OR CREMATORIAL Kalbaugh Cemetery		22d. LOCATION (City, town, or county) (State) Elk Garden, W. Va.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 3, 1958		24c. REC'D BY REGISTRAR <input type="checkbox"/> DATE MAY 5 '58		
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight Cumberland, Md.		ADDRESS		24d. REGISTRAR'S SIGNATURE <i>John J. Kight</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04072

4070 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN b 9 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d. STREET ADDRESS 1922 BEDFORD STREET	
3. NAME OF DECEASED (Type or print)	First C.	Middle EDWARD	Last SCHLUND
4. DATE OF DEATH	Month APRIL	Day 11	Year 19 58
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 28, 1878
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years from last birthday) 79 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY - Greenhouse florist	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN C. SCHLUND		14. MOTHER'S MAIDEN NAME MARY GOOR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/7/48 , 19, to 4/11/58 , 19, that I last saw the deceased alive on 4/11/58 , 19, and that death occurred at 10:40 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE R.J. Williams, M.D. PHYSICIAN'S NAME (Type) DR. R.J. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/14/58	
22c. NAME OF CEMETERY OR CREMATORIAL Trinity Lutheran		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland, Maryland	
		24a. REC'D BY REGISTRAR DATE APR 15 1958 Ruth E. Silcox	
		24b. REGISTRAR'S SIGNATURE	

BUREAU
K&E

APR 16 1958

K&E VIDEO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4071

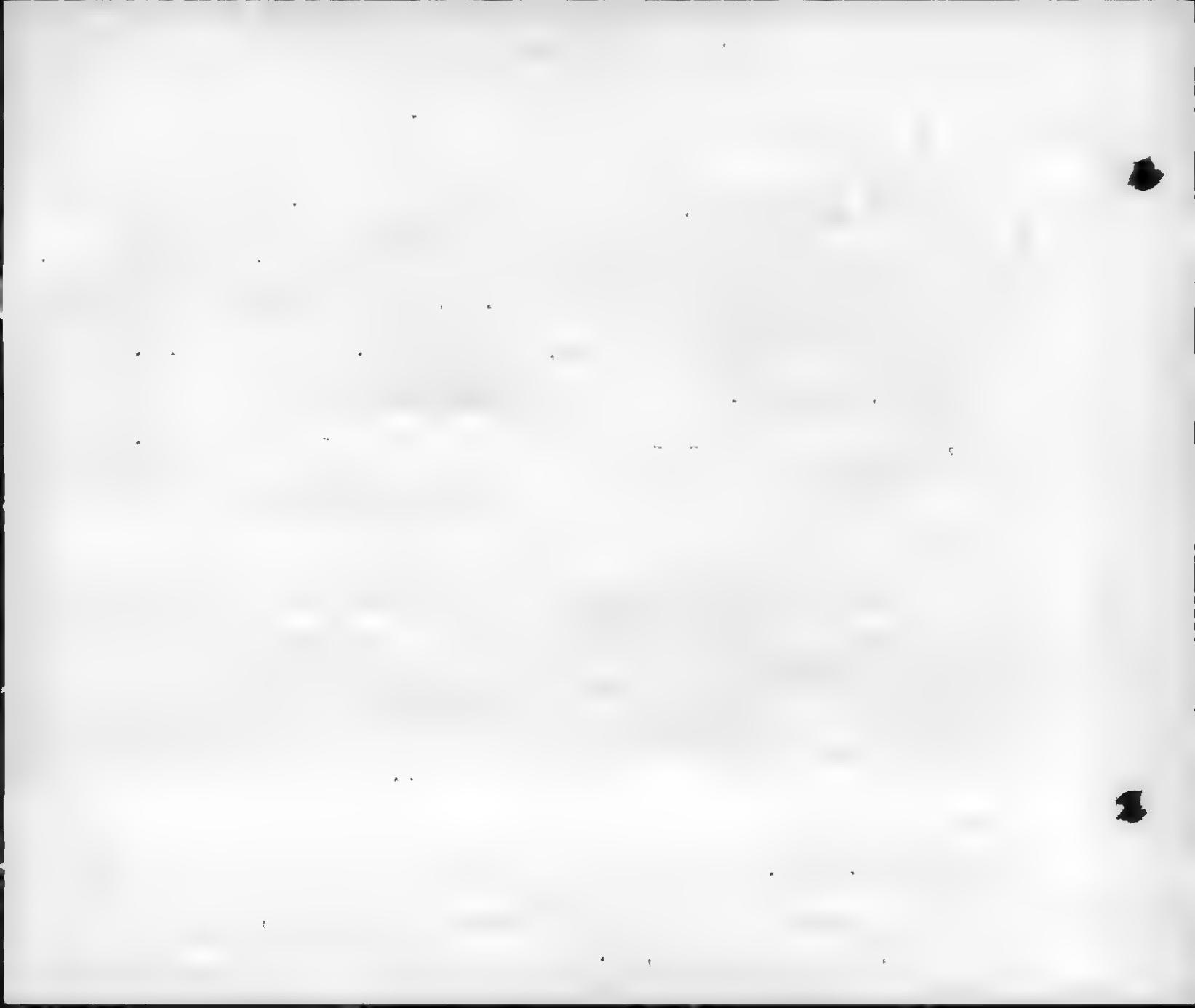
CERTIFICATE OF DEATH

Reg. Dist. No.

04073

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 65 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
3. NAME OF DECEASED (Type or print) ROBERT		First ROBERT	Middle DEMSEY
4. DATE OF DEATH SECRI		Month APRIL	Day 27
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH FEB. 23, 1900		9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jalesian		10b. KIND OF BUSINESS OR INDUSTRY Burns Cuboid Co.	
11. BIRTHPLACE (State or foreign country) BUCHANAN, VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ROBERT D. SECRI SR.		14. MOTHER'S MAIDEN NAME Nannie Linkenhoker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No,		16. SOCIAL SECURITY NO 095-01-1632	17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene, both legs		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerosis			
DUE TO (c) Diabetes Mellitus			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 21. I certify that I attended the deceased from <u>2/21</u>, 19<u>58</u>, to <u>4/27</u>, 19<u>58</u>, that I last saw the deceased alive on <u>4/27</u>, 19<u>58</u>, and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.
ACTUAL SIGNATURE <i>Dr. Leo H. Ifey Jr.</i>		ADDRESS (Street, city or town, state) 42 N. Centre St Cumberland Ind	
PHYSICIAN'S NAME (Type) DR. LEO H. IFY		DATE SIGNED 4/28/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/58	22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park
22d. LOCATION (City, town, or county) Cumberland, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Md.		24a. REC'D BY REGISTRAR Al. Seach	24b. REGISTRAR'S SIGNATURE
		DATE MAY 1 '58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4072

CERTIFICATE OF DEATH

Reg. Dist. No. 04074

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE W. Va.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6 weeks				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Edna	Middle Raigner	Last Sharp			
4. DATE OF DEATH	Month April	Day 14	Year 1958			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7, 1913			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U. S. Post Office	11. BIRTHPLACE (State or foreign country) Paw Paw, W. Va.			
13. FATHER'S NAME Elmer Raigner		14. MOTHER'S MAIDEN NAME May Goldsboro				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Don C. Sharp, Paw Paw, W. Va.	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month Apr. Day 14 Year 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Paw Paw	20f. (City or town) Paw Paw	(County) W. Va.	(State) W. Va.
21. I certify that I attended the deceased from Jan. 1948 to Apr. 14, 1958 , that I last saw the deceased alive on Apr. 14, 1958 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>John A. Topper</i>	ADDRESS (Street, city or town, state) Hagerstown, Pa.			DATE SIGNED 4/15/58		
PHYSICIAN'S NAME (Type) Dr John Topper	Hyndman			Pennsylvania		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/16/58	22c. NAME OF CEMETERY OR CREMATORIUM Camp Hill		22d. LOCATION (City, town, or county) (State) Paw Paw, W. Va.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. Johnson</i>	ADDRESS Berkeley Brgs. W. Va.	24a. REC'D BY REGISTRAR APR 18 '58		24b. REGISTRAR'S SIGNATURE <i>John E. Johnson</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU U.S.

JAN 15 1969

DEPARTMENT OF DEFENSE

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04075

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

D.O.A.

I

1. PLACE OF DEATH a. COUNTY		4092		Reg. Dist. No.	
Allegany		MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		2 USUAL RESIDENCE (Where deceased lived II institution; Residence before admission)	
Frostburg				a. STATE	Md.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS		b. COUNTY	Allegany
Miners Hospital		X La Vale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
		9 Richard Way, Coverwood.			
3. NAME OF DECEASED (Type or print)		First Margaret Smith MacFarlane		4. DATE OF DEATH	Month April Day 10 Year 1958
Middle Shaw		Last		9. AGE (In years last birthday) 25 yrs.	IF UNDER 14 YEARS Months Days Hours Min.
5. SEX Female		6. COLOR OR RACE white		7. MARRIED WIDOWED	8. DATE OF BIRTH May 25-1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
retired laboratory technician & Housewife				Cumberland, Md.	
13. FATHER'S NAME John B. Mac Farlane		14. MOTHER'S MAIDEN NAME E Elizabeth Grant		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT (husband) Andrew B. Shaw, LaVale, Md.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X		Exsanguination due to a 38 caliber		Address	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) revolver wound in chest, near left nipple		INTERVAL BETWEEN ONSET AND DEATH sudden	
(c) region, self inflicted.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Shot herself with a 38 caliber revolver in left chest.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> * <input checked="" type="checkbox"/> April 10 1958 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
				20f. (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 11-1958	
EXAMINER'S NAME (Type) H. V. Deming M.D.		22c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill		22d. LOCATION (City, town, or county) Moscow	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial 4/13/58		22b. DATE THEREOF		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. Boal</i>		ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DA APR 15 '58	
				24b. REGISTRAR'S SIGNATURE <i>B. L. Finch</i>	

BUREAU V. S.

APR 15 1958

CONFIDENTIAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04076

4093

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Allegany		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		d. STREET ADDRESS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First william	Middle 	Lost Shearer	4. DATE OF DEATH April	Month 6	Day 19	Year 58		
S SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH July 10, 1889	9. AGE (In years lost birthday) 68 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours 	Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Midland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME william Shearer		14. MOTHER'S MAIDEN NAME Elizabeth Goodrich							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Wilbert Rennie		Address Lenacening, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute left Ventricular failure 2 days DUE TO (c) Diabetic Nephritis, Urinary						INTERVAL BETWEEN ONSET AND DEATH years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frostburg		(County) Allegany	(State) Md.
21. I certify that I attended the deceased from 9/5 , 1958, to 9/6 , 1958, that I last saw the deceased alive on 9/5 , 1958, and that death occurred at 10:55 AM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Frostburg, Md.		DATE SIGNED	
ACTUAL SIGNATURE John C. Deas				M.D. John C. Deas		134 E Main St.			
PHYSICIAN'S NAME (Type) John C. Deas						Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/9/58		22c. NAME OF CEMETERY OR CREMATORY Vale Summit Cemetery		22d. LOCATION (City, town, or county) Vale Summit, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lenacening, Md.		24a. REC'D BY REGISTRAR APR 9 '58		24b. REGISTRAR'S SIGNATURE George Eichhorn			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PELLEAU V. S.

APR 9 1953

PEGEIV EU

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

Vs ABC-155 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

4104

04077

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)	MARYLAND LENGTH OF STAY (in this place)	STATE Md. CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	COUNTY Garrett (If rural give location)
Allegany Rawlings	3 yrs.	X Deer Park	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	/ STREET ADDRESS		
3. NAME OF DECEASED (Type or Print)		(First) Edward	(Middle) Eli
		(Last) Sollars	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct 6 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) M.D.	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 73 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min
13. FATHER'S NAME Edward E. Sollars		11. BIRTHPLACE (State or foreign country) Hoyes, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS Edw. Eli Sollars, Jr., DeerPark, Md
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 10 years	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <i>Artherosclerotic cardiovascular disease</i>		ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) _____ (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan 1956</i> , to <i>April 21, 1958</i> , that I last saw the deceased alive on <i>Jan 21, 1958</i> , and that death occurred at <i>8:00 a.m.</i> from the causes and on the date stated above. SIGNATURE <i>James Westbrook Jr.</i> ADDRESS (Street, city, town, state) <i>Pickmont W. Va.</i> DATE SIGNED <i>4-21-58</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THIS OF Apr. 23/58	NAME OF CEMETERY OR CREMATORIUM DeerPark Cemetery	LOCATION (City, town, or county) Deer Park, Md. (State)
24. REC'D BY REGISTRAR APR 28 '58	REGISTRAR'S SIGNATURE <i>Albert French</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Bethel L. French Home Occupation, Farmer Husband Oaklawn, Md.</i>	
DATE	ADDRESS		

BUREAU V. A.

APR 29 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4073

CERTIFICATE OF DEATH

Reg. Dist. No. 04078

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 15 MINS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAVALE		d. STREET ADDRESS MC HENRY ST.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JAMES		First C.	Middle .	Last STORER	4. DATE OF DEATH APRIL 22 1958	Month APRIL	Day 22	Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 2	9. AGE (in years past birthday) yrs. 54	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days 4	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN KELLY		10b. KIND OF BUSINESS OR INDUSTRY Tire Industry		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME ERNEST STORER		14. MOTHER'S MAIDEN NAME GRACE W. SPIER							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-0863		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO <i>Coronary Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH 1 day					
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c)		DUE TO							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) CUMBERLAND		(County) MARYLAND	(State) MARYLAND
21. I certify that I attended the deceased from 2/3/58 , 19, to 4/22/58 , 19, that I last saw the deceased alive on 4/21/58 , 19, and that death occurred at 9:45 PM , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) CUMBERLAND, MD.									
ACTUAL SIGNATURE <i>R. J. Williams M.D.</i>									
PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-58		22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.		(State) MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR APR 25 '58		24b. REGISTRAR'S SIGNATURE <i>James F. Scarpelli</i>			

3. A REVIEW

John C. de

1. APPROX.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4074

CERTIFICATE OF DEATH

Reg. Dist. No.

04079

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS Braddock Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Braddock Road				d. STREET ADDRESS Braddock Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Mrs. Cora Elizabeth Terry		First	Middle	Lost	4. DATE OF DEATH April 20 1958	Month	Day	Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1879	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Lemhi, Idaho		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Zephania Yeariam			14. MOTHER'S MAIDEN NAME Sara Jane Yeariam					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Dr. R. Rhett Rathbone, Cumberland, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema INTERVAL BETWEEN ONSET AND DEATH 10 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mediastinal Metastasis 4 month (c) Bronchogenic Carcinoma Left Lung 10 Months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July 11, 1957 to April 20, 1958 , that I last saw the deceased alive on April 20, 1958 , and that death occurred at I p M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 122 S. Centre St., Cumberland, Md. DATE SIGNED								
ACTUAL SIGNATURE R. Rhett Rathbone		M.D.						
PHYSICIAN'S NAME (Type) Dr. R. Rhett Rathbone		April 20, 1958						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-23-58		22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Miami, Fla.		
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 22 '58		24b. REGISTRAR'S SIGNATURE W. J. Geddes		

BUREAU V. S.

APR 02 1953

PAGE ONE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4075

CERTIFICATE OF DEATH

Reg. Dist. No. 04080

1. PLACE OF DEATH a. COUNTY		Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		a. STATE Maryland	b. COUNTY Allegany
Cumberland		3/17/58		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Allegany County Infirmary		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First John	Middle J.	Last Tipton	4. DATE OF DEATH April	Month 7, Day Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 1/8/1871	9. AGE (in years last birthday) 07 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Teacher		10b. KIND OF BUSINESS OR INDUSTRY School Teacher		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Noah Tipton		14. MOTHER'S MAIDEN NAME Lavina Cook		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 335-16-7763		17. INFORMANT P.O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Hypogesitalia, cha Seville</u>					
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>AtrioSclerosis, Seville</u>					
DUE TO					
(c) <u>Diabetes Acclitus</u>					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/17/58, 19, to 4/7/58, 19, that I last saw the deceased alive on 4/7/58, 19, and that death occurred at 7:50A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>C. Mathews, M.D.</u> ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED 4/7/58					
PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews Cumberland, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/9/58		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Mausoleum	
22d. LOCATION (City, town, or county) Cumberland, Maryland (State)					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. Wayne George Cumberland, Md.					
24a. REC'D BY REGISTRAR DATE APR 11 '58					
24b. REGISTRAR'S SIGNATURE <u>G. L. couch</u>					

BUREAU V. S.

APR 11 1959

REGULATIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4076 CERTIFICATE OF DEATH

04081

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First EVA	Middle M.	Last TROUT
4. DATE OF DEATH	Month APRIL	Day 9	Year 1958
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1904 XOCTOBER 22, 1958
9. AGE (in years last birthday) 55	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 MRS Days 33	12. IF UNDER 24 MRS Hours hrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN WILLIAMS	14. MOTHER'S MAIDEN NAME LOTTIE STEINE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO 215-36-7213	17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>General metastatic carcinoma originating in female organs</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>in female organs</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1956 , to April 9 , 1958, that I last saw the deceased alive on April 8 , 1958, and that death occurred at 5:00A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Carlton Brinsfield</i>	ADDRESS (Street, city or town, state) 232 Britton Ave Cumberland Md.		
PHYSICIAN'S NAME (Type) DR. C. BRINSFIELD	DATE SIGNED April 19, 1958		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 11, 1958	22c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	22d. LOCATION (City, town, or county) Cumberland, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland	ADDRESS	24a. REC'D BY REGISTRAR Alv. esher	24b. REGISTRAR'S SIGNATURE
VS A15 (4) 1SM 10/57	DATE APR 14 '58		

REF ID: V.2

APR

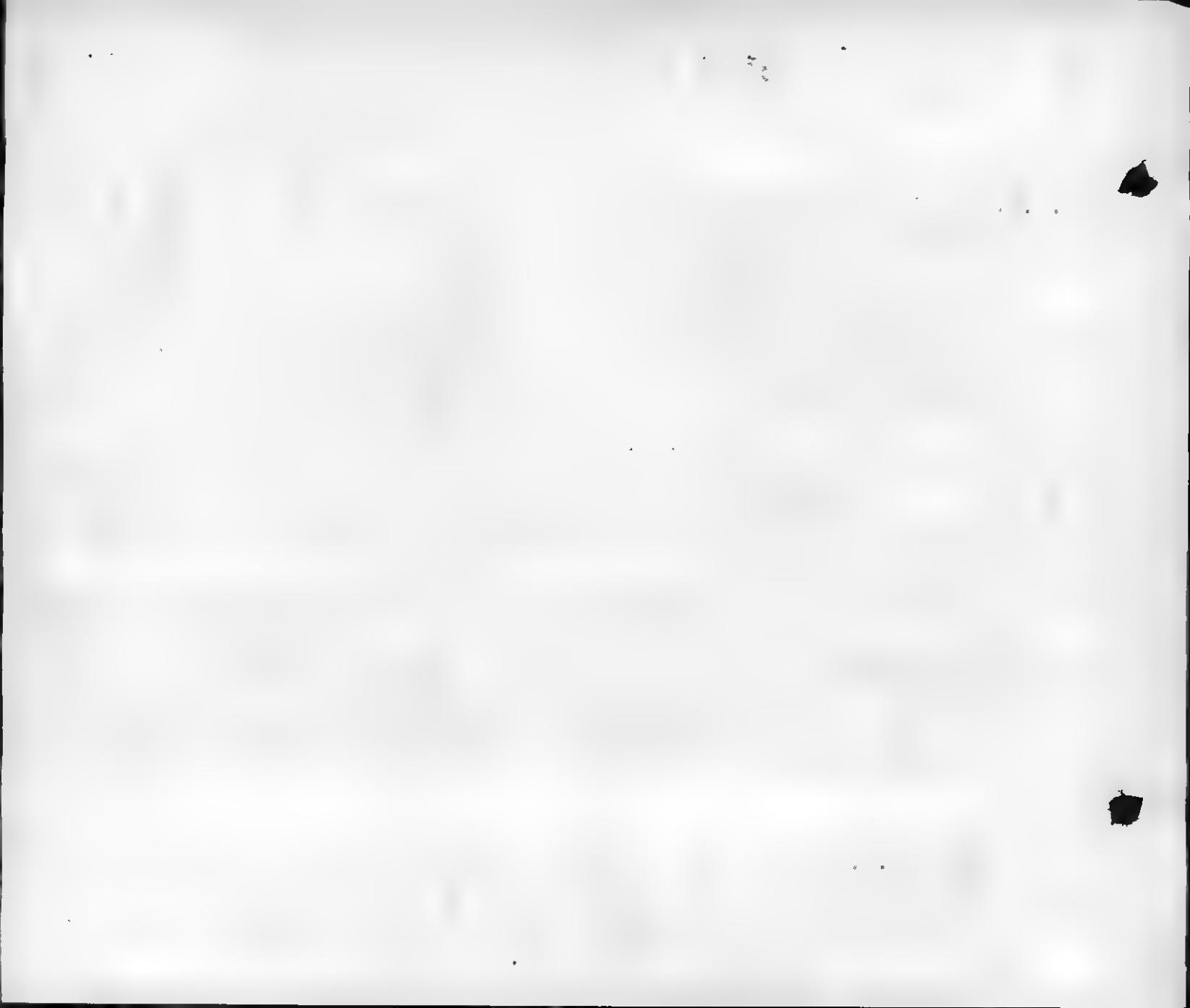
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
- MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04082

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day 4 or more days, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
 A should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		4994 Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md b. COUNTY Allegany		Reg. Dist. No _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 40 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		• IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. at Miners Hospital				d. STREET ADDRESS 156 Mc Culloch St.					
3. NAME OF DECEASED (Type or print)		First Richard	Middle	Last Truly	4. DATE OF DEATH April	Month	Day 28	Year 19 58	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 8-1882		9. AGE (In years last birthday) 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired-Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lonaconing, Md,		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Truly				14. MOTHER'S MAIDEN NAME Margaret Graham					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT 2T4-T6-2032 (son) Lloyd Truly, Frostburg, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion				INTERVAL BETWEEN ONSET AND DEATH sudden about 2 weeks			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Coronary sclerosis							
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While or work <input type="checkbox"/> Not while or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 29-1958			
EXAMINER'S NAME (Type) H.V. Deming M.D.									
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-1-1958		22c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Pk.		22d. LOCATION (City, town, or county) Frostburg Md.			
22e. FUNERAL DIRECTOR'S SIGNATURE <i>George W. Mettinger</i>		22f. ADDRESS Frostburg, Md.		22g. REC'D BY REGISTRAR DATE MAY 5 '58		22h. REGISTRAR'S SIGNATURE <i>Albert J. Schuck</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4077

CERTIFICATE OF DEATH

Reg. Dist. No.

04083

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		d. STREET ADDRESS 34 Greene St.,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hosp.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARIZONA		First ETHEL	Middle VANDERGRIFT	4. DATE OF DEATH April 16, 1958	Month April	Day 16	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X	8. DATE OF BIRTH Sept. 18, 1884	9. AGE (In years last birthday) 73 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Monongalia Co. W. Va.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Oregon Vandergrift		14. MOTHER'S MAIDEN NAME Louernia Williams					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No,		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Flora G. Robinette		Address 32 Greene St., Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Stomach DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. } (b) Abdominal carcinomatosis DUE TO none (c)						INTERVAL BETWEEN ONSET AND DEATH 2 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 140 Bedford St.,	
21. I certify that I attended the deceased from March 22, 1958, to April 16, 1958, that I last saw the deceased alive on April 16, 1958, and that death occurred at 2:15 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>James P. Hallinan M.D.</i> ADDRESS (Street, city or town, state) M.D. 140 Bedford St.,							
PHYSICIAN'S NAME (Type)		Physician's Name James P. Hallinan M. D.		Cumberland, Md.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/19/58		22c. NAME OF CEMETERY OR CREMATORIUM Shinnston Masonic Cemetery		22d. LOCATION (City, town, or county) Shinnston, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.		24a. REC'D <input type="checkbox"/> REGISTRAR <input type="checkbox"/> 24b. REGISTRAR'S SIGNATURE DATE APR 18 1958			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

19 1050

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04084

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lenaconing			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS Railroad Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Douglas	Middle G.	Last Waddell	4. DATE OF DEATH April 28 1958	Month April	Day 28	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 21, 1871	9. AGE (in years last birthday) 87 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	
10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Lenaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Waddell			14. MOTHER'S MAIDEN NAME Jessie Graham				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. no 214-32-3177		17. INFORMANT Mrs. Douglas Waddell		Address Lenaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart</i>							
DUE TO (b) <i>Bang. D. lab. - High</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (c) <i>C. b. heart disease</i>							
DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Lenaconing	(County) (State)
21. I certify that I attended the deceased from <i>March 1, 1958</i> to <i>April 28, 1958</i> , that I last saw the deceased alive on <i>April 27, 1958</i> , and that death occurred at <i>Lenaconing, Md.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>Jessie R. Waddell Jr.</i> M.D. <i>MAIN</i> 7-21-58							
PHYSICIAN'S NAME (Type) <i>LESTER R. MILLIS JR.</i> <i>LONA CONING, MD.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/30/58	22c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery			22d. LOCATION (City, town, or county) Lenaconing, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lenacening, Md.	24a. REC'D BY REGISTRAR DATE 5 '58		
							24b. REGISTRAR'S SIGNATURE <i>W. J. Schaeffer</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4078 CERTIFICATE OF DEATH

Reg. Dist. No. 04685

1. PLACE OF DEATH a. COUNTY		Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6/8/57		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				d. STREET ADDRESS Benjamin Benaker Apts.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Mary	Middle Mamie	Last Washington	4. DATE OF DEATH April 9, 1958	Month April	Day 9	Year 1958
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/14/1890		9. AGE (In years less birthday) 67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Oldtown, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT P.O. Box 599 Allegany County Infirmary Records		Address Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2		DUE TO <i>Hypertension, Chronic degenerative</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		(b) DUE TO <i>Cerebral arteriosclerosis,</i>						
		(c) <i>Cocleuria; Residual of hypertension</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D. 49 Greene Street	(County) (State) Cumberland, Maryland	
21. I certify that I attended the deceased from 6/8/57, 19, to 4/9/58, 19, that I last saw the deceased alive on 4/9/58, 19, and that death occurred at 8:35 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 49 Greene Street		
ACTUAL SIGNATURE <i>Dr. Lee B. Mathews</i>						DATE SIGNED 4/9/58		
PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 11, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		24a. REC'D BY REGISTRAR APR 14 '58		24b. REGISTRAR'S SIGNATURE <i>Lee B. Mathews</i>		

SEARCHED

APR

INDEXED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, File G223, 4/21/58, Fox

CERTIFICATE OF DEATH

Reg. Dist. No. 04086

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 722 ELM STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First FLORENCE	Middle W.	Last WEIRES	4. DATE OF DEATH	Month APRIL	Day 7	Year 1958
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 21, 1898	9. AGE (in years (at birthday) 60 89 yrs	IF UNDER 1 YEAR Months 60	IF UNDER 24 HRS. Days 89	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA -Myersdale		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN BAKER				14. MOTHER'S MAIDEN NAME REBECCA FLOTO			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 218-24-8086		17. INFORMANT PATIENT'S NIECE		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hypertensive C-V Disease				INTERVAL BETWEEN ONSET AND DEATH acute			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cardiac Hypertrophy				5 yrs. 3 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 2, 1958 to Apr. 7, 1958 , that I last saw the deceased alive on Apr. 7, 1958 , and that death occurred at 2:10 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 4/8/58							
ACTUAL SIGNATURE James F. Scarpelli		PHYSICIAN'S NAME (Type) James F. Scarpelli, Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-10-58		22c. NAME OF CEMETERY OR CREMATORIAL Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR APR 10 '58		24b. REGISTRAR'S SIGNATURE Releasid	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURGESS V. S.

CC TO 1958



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04087

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		Reg. Dist. No.	
a. COUNTY <u>Allegheny</u>		b. STATE <u>MARYLAND</u>		c. COUNTY <u>Allegheny</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN lb <u>84 yrs</u>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Technic Heart Institute</u>		e. STREET ADDRESS <u>11 Bedford St</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
g. LENGTH OF STAY IN lb <u>84 yrs</u>		h. DATE OF DEATH <u>April 7 1958</u>			
3. NAME OF DECEASED (Type or print) <u>Amelia</u>		First <u>T.</u> Middle <u>J.</u> Last <u>white</u>		4. DATE OF DEATH <u>April 7 1958</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>June 26-1873</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTH-PLACE (State or foreign country) <u>Cumberland, Md.</u>	
13. FATHER'S NAME <u>George Leibrant</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Reub</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>daughter Mrs. Henry Lee, Cumberland, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>terminal</u>			
DUE TO <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u>					
(b) DUE TO <u>Chronic myocarditis</u>		?			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) <u>(County) (State)</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>April 7-1958</u>	
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 7-1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 9, 1958</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>St. Lukes Luth. Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Cumberland, Maryland</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		ADDRESS		24e. REC'D BY REGISTRAR <u>APR 10 '58</u>	
				24f. REGISTRAR'S SIGNATURE <u>Reese</u>	

BUREAU V. S.
APR 10 1968
DEPARTMENT OF DEFENSE

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate may be retained by the hospital or attending physician.

VS AISC 155 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04088

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN give nearest town)	Allegany MARYLAND Length of stay (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town)	Md. Allegany (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Residence	Luke	TOWN STREET ADDRESS	Luke 430 Pratt St.
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) George (Middle) Oliver (Last) Williams		Month (Dey) (Year) April 15 19 58	
SEX Male	COLOR OR RACE White	SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	DATE OF BIRTH Jan 5 1893
AGE last birthday 65	IF UNDER 1 YEAR Months Days Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Papermaker	10b. KIND OF BUSINESS OR INDUSTRY W.Va. P & P co.	11. BIRTHPLACE (State or foreign country) Piedmont, W.Va	12. CITIZEN OF WHAT COUNTRY? U.S
FATHER'S NAME O.D. Williams	14. MOTHER'S MAIDEN NAME Leota Rector		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no	16. SOCIAL SECURITY NO. 216-05-9744		
17. INFORMANT & ADDRESS Oliver Williams, Luke, Md.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Generalized Carcinoma ANTECEDENT CAUSE(S) DUE TO Generalized Carcinoma DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Carcinoma base of Tongue (C) 18 mo.			
INTERVAL BETWEEN ONSET AND DEATH 6 mo.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) Piedmont (State) W. Va.			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 1, 1957, to April 5, 1958, that I last saw the deceased alive on April 5, 1958, and that death occurred at 4 P.M. from the causes and on the date stated above.			
SIGNATURE E. Berry		ADDRESS (Street, city, town, state) Piedmont, W. Va.	
DATE SIGNED 4/15/58			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF April 19.58	
NAME OF CEMETERY OR CREMATORIUM Philos Cemetery		LOCATION (City, town, or county) Westernport, Md.	
24. REC'D BY REGISTRAR APR 8 '58		REGISTRAR'S SIGNATURE John E. Berry	
DATE APR 8 '58		25. FUNERAL DIRECTOR'S SIGNATURE John E. Berry, Piedmont, W. Va.	

RECEIVED
MAY 2 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4081 CERTIFICATE OF DEATH

Reg. Dist. No. 04089

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6/7/54	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d. STREET ADDRESS 211 Cecelia Street	
3. NAME OF DECEASED (Type or print) Daisy W. Wilson		First	Middle
4. DATE OF DEATH April 3, 1958		Last	Month
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 10/13/1886		9. AGE (In years lost birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Seamstress - Rosenbaum's		10b. KIND OF BUSINESS OR INDUSTRY Rawlings, Maryland	
11. BIRTHPLACE (State or foreign country) Rawlings, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John F. Wilson		14. MOTHER'S MAIDEN NAME Esther Chaney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service None		16. SOCIAL SECURITY NO. 214-05-8351	
17. INFORMANT P.O.Box 599 Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 22 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic nephritis		?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/7/54 , 19, to 4/3/58 , 19, that I last saw the deceased alive on 4/3/58 , 19, and that death occurred at 4:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED 4/4/58			
ACTUAL SIGNATURE James E. McLean M.D.		PHYSICIAN'S NAME (Type) Dr. James E. McLean	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/7/58	
22c. NAME OF CEMETERY OR CREMATORIAL Greenmount Cem.		22d. LOCATION (City, town, or county) Cumb. Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		ADDRESS Cumb. Md	
24a. REC'D BY REGISTRAR DATE 1987 '58		24b. REGISTRAR'S SIGNATURE Debrauch	

BRUNEAU V. S.
1953
PREG-JA EDO

118

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4-96

CERTIFICATE OF DEATH

Reg. Dist. No. 04090

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG, MD	c. LENGTH OF STAY IN lb	b. COUNTY ALLEGANY	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BARTON, MD
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS Hosp, Frostburg, Md.	d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) LUVENA	First	Middle	Last
S. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 20 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY OWN Home	11. BIRTHPLACE (State or foreign country) GARRETT Co., MD	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JACOB BITTINGER	14. MOTHER'S MAIDEN NAME ELIA FAZENBAKER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. —	17. INFORMANT Mrs Alvie Moore, Barton, Md	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 260x		INTERVAL BETWEEN ONSET AND DEATH 2 weeks years	
(b) Intemis clavis			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Mar 31, 1958 , to April 10, 1958 , that I last saw the deceased alive on April 10, 1958 , and that death occurred at 11 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) MAIN ST. DATE SIGNED 4-11-58			
ACTUAL SIGNATURE Leslie R. Miles Jr.			
PHYSICIAN'S NAME (Type) LESLIE R. MILES JR			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/13/58	22c. NAME OF CEMETERY OR CREMATORIAL BITTINGER
23. FUNERAL DIRECTOR'S SIGNATURE Don Norman, Grantsville, Md		ADDRESS	24a. REC'D BY REGISTRAR ADB 16 '58
			24b. REGISTRAR'S SIGNATURE Don Norman

RECEIVED STATE GOVERNMENT OF MARYLAND - BALTIMORE 20
CERTIFICATE OF DEATH

DEATH

BUREAU X-1

APR 16 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4091

FOR STATE
HEALTH DEPT.

TO DEFUNCT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 57 Yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 420 Grand Ave.		e. STREET ADDRESS 1420 Grand Ave.	
3. NAME OF DECEASED (Type or print) Charles		First Edgar	Middle Zimmerman
4. DATE OF DEATH April 7 1958	Month Day Year	5. SEX male	6. COLOR OR RACE white
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16-1900	9. AGE (In years last birthday) 57	10. IF UNDER 1 YEAR Months Days
11. BIRTHPLACE (State or foreign country) Cumberland, Md.	12. IF UNDER 24 HRS. Hours Min.	13. FATHER'S NAME John E. Zimmerman	14. MOTHER'S MAIDEN NAME Mildred Racey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 705-05-4835	17. INFORMANT (son) Charles Zimmerman, Old Town, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH sudden	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Coronary occlusion	
DUE TO (c)		Coronary sclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 7-1958
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 4-10-1958	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	22d. LOCATION (City, town, or county) Cumberland, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.	ADDRESS <i>Scarpelli</i>	24a. REC'D BY REGISTRAR APR 10 '58	24b. REGISTRAR'S SIGNATURE <i>Ale. Leach</i>

SEARCHED
INDEXED

STATE OF SOUTH DAKOTA
DEPARTMENT OF STATE
DIVISION OF RECORDS

BUREAU Y. S.

APR 10 1953

REGELV ELL